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The Report of ...

THE ALBERTA TASK FORCE ON NURSING EDUCATION

September 1975

Alberta
ADVANCED EDUCATION
AND MANPOWER

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THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2E6

September 29, 1975

The Honourable A.E. Hohol
Minister of Advanced Education and Manpower
Legislative Building
Edmonton, Alberta
T5K 2B6

Dear Dr. Hohol:

I have the honour to submit to you herewith the Report of the Alberta Task Force on Nursing Education which was commissioned by your predecessor, the Honourable James L. Foster, on January 24, 1975.

The Task Force held its first meeting on Tuesday, January 28 and subsequently held nine meetings of two days each through the months of March through September.

I should like to refer here to the high competence and dedication of the members of the Task Force and of the members of your Department who were responsible for drafting the report. Their names are recorded in the preliminary pages of the report.

Yours sincerely,

Walter H. Johns

Walter H. Johns
Chairman
Alberta Task Force on Nursing Education

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Alberta

ADVANCED EDUCATION

403/229-3679

Office of
the Minister

425 Legislative Building
Edmonton, Alberta, Canada T5K 2B6

January 24, 1975

Dr. Walter H. Johns
Professor Emeritus
The University of Alberta
EDMONTON, Alberta

Dear Dr. Johns:

In your capacity as Chairman, of the Alberta Task Force on Nursing Education, I request that you convey to all members of the Task Force the appreciation and good wishes of myself and the Government of Alberta for the important work that they are about to undertake.

With regard to health sciences education generally, my Department is charged with implementing the policy on the education and training of health manpower, but as well it must carry out its general mandate of providing leadership, service, and coordination to an overall system of advanced education responsive to the needs of all Albertans.

To accomplish this two-fold task in the area of nursing education, the Department requires specific kinds of information and advice in a form consistent with the overall sphere of responsibility outlined above.

The attached terms of reference indicate the expectations and requirements of the Department of Advanced Education with respect to the work of the Task Force. In requesting that you address the specified issues within a particular format, I am aware that the task is both large and difficult. However, I am sure you will agree that the goal of providing Alberta citizens with a high quality system of nursing education and service is well worth the required effort.

I look forward to receiving your Report.

Yours sincerely

James L. Foster
Minister

TERMS OF REFERENCE

General Objective

To prepare a framework within which planning and coordination for the education of nursing personnel in Alberta can be carried out.

Specific Issues

In preparing the above "framework for planning and coordination," the Task Force is asked to examine and report on the following issues, each of which is considered to be an integral element of the overall planning framework:

1. The current health service needs of Albertans and their expectations of their health service.

2. The current system for delivering needed health services, and the practices employed in doing so.

3. Anticipated, predicted and desirable changes or shifts of emphasis in the health-care delivery system and the practices therein.

4. The role of nursing service within the health-care delivery system now and as anticipated, predicted, and desired in the future.

5. The specific categories or types of nursing personnel required for the current and evolving health-care system.

6. The competencies required of the various categories of nursing personnel to fulfill the role described in (4) and to meet the requirements specified in (5).

7. The total educational system required to produce graduates with competencies described in (6).

8. The relationships between and among pre-service education, orientation, in-service education, and further education within the total educational system described in (7).

9. The way in which the various parts of the educational system described in (7) and (8) must be articulated to enable each member of the nursing labour force to achieve her/his maximum level of competence to ensure both personal satisfaction and enhanced quality of nursing service.

10. The mechanism required to monitor the educational system described in (7), (8), and (9) to maintain determined standards.

MEMBERS OF THE ALBERTA TASK FORCE ON NURSING EDUCATION

Dr. W. H. Johns, Chairman	Professor Emeritus University of Alberta
Mrs. P. Fredrickson	Past-President Alberta Certified Nursing Aide Association
Mrs. E. Marliss	Consumer Affairs Commentator
Dr. A. R. Murray	Practising Physician
Miss R. B. Palfrey	Nurse Clinician Foothills Hospital
Mrs. L. Rutherford	Director Mount View & Foothills Health Units
Dr. J. Scholdra	Chairman, School of Health Services Lethbridge Community College
Miss M. Schumacher	Dean, Faculty of Nursing University of Calgary
Miss B. Sellers	Nursing Service Consultant Alberta Association of Registered Nurses
Dr. B. Snell	Executive Director University of Alberta Hospital
Mrs. D. Stevenson	Director Holy Cross School of Nursing
Mr. B. Vriens	President Elect Alberta Association of Registered Nursing Orderlies
Dr. J. G. Woodsworth	Professor, Department of Educational Psychology University of Calgary

Mr. R. Coombs, Executive Director, Foothills Hospital, acted as an alternate for Dr. B. Snell.

In addition to the above official members, the Task Force was provided with the services of the following resource personnel from the Department of Advanced Education and Manpower.

Dr. D. E. Berghofer	Executive Secretary	Director, Special Program Services
Dr. J. Peitchinis	Consultant	Consultant on Nursing Education
Ms. C. Mailloux	Consultant	Consultant on Nursing Education
Ms. M.J. St. Pierre	Recording Secretary	Research Officer

ACKNOWLEDGEMENTS

It would be invidious, if not impossible, to attempt to record the names of individuals, associations, and groups who contributed helpful suggestions and comments, both written and oral, and thereby aided the Task Force in its work. We have tried to acknowledge all these contributions directly, but if any have been inadvertently overlooked, we express our thanks at this time.

Some of the views and comments we received are reflected in the pages of the report itself and some are embodied in the recommendations. In every case we did appreciate very much the interest and help from so many sources.

Special reference must be made to the contribution of Dr. Jacquelyn Peitchinis who was responsible for drafting the early chapters of the report and to Miss Anne Denholm, Mrs. Sharon Lindberg, Ms. Mary Joan St. Pierre, Ms. Claire Mailloux and Dr. Des Berghofer of the office of Special Program Services, Department of Advanced Education and Manpower, who carried out the difficult task of preparing the final draft. Their efforts went far beyond the normal call of duty and without their vital contribution, the report could not have appeared.

Walter H. Johns, Chairman
on behalf of the members of the
Alberta Task Force on Nursing Education

GLOSSARY OF TERMS

ARTICULATED BACCALAUREATE PROGRAM: An undergraduate nursing program planned jointly between a non-university faculty and a university faculty in such a sequence as to provide for opportunities for entry, exit and re-entry with maximum ease without excessive loss of time or academic credit.

CLINICAL ELECTIVE: A course which is initiated, developed and monitored by a faculty and which students can select as an option.

CONCENTRATED STUDY: Immersion in an area of high interest by the student in a particular area of focus within clinical nursing. Such a course is required of all students.

DIPLOMA PROGRAM: An approved program taken within a non-university institution wherein eligibility to write the registration examinations is concurrent with obtaining the diploma conferred by the institution.

DISTRIBUTIVE NURSING PRACTICE: That area of concentration in nursing practice which emphasizes prevention of disease and maintenance of health and is largely directed toward continuous care of persons not confined to health care institutions. (Lysaught, 1974:31).

EPISODIC NURSING PRACTICE: That area of concentration in nursing practice which emphasizes the curative and restorative aspect of nursing which usually involves patients with diagnosed disease, either acute or chronic. (Lysaught, 1974:31).

HEALTH-CARE DELIVERY MODEL: A model which places emphasis on the promotion of health and the prevention of illness for population groups within their environmental context. Part of this model is the consumer's right to have all available information necessary to enable him to participate along with all health-care providers in decisions relating to his care. (Tinkham and Voorhies, (1972:125).

INDEPENDENT STUDY: A student-initiated course with contractual agreement between a student and faculty for pre-defined competency-based objectives.

MEDICAL-CARE DELIVERY MODEL: A model which places emphasis on the diagnosis and treatment of disease in the individual by the physician. All the information about the individual is given to the physician who in turn makes the decisions about what the individual's treatment shall be, and what he shall be told about his illness. (Tinkham and Voorhies, 1972:125).

NON-UNIVERSITY INSTITUTION: A college or hospital school offering a nursing program.

PRE-SERVICE PROGRAMS: Those programs which prepare the graduate nurse for eligibility to write the registration examinations.

PRIMARY CARE: Those health-service functions which deal with the well, the worried well, the pre-symptomatic and the early symptomatic. It includes the initial point of contact with the

health-care system and the assurance of continuing contact over time. Emphasis is placed on patient education, disease prevention and long-term management of care in a coordinated continuous fashion. Nursing practice in this area is mainly distributive in nature. Clinical facilities associated with the above include physicians' offices, clinics, homes, industrial and commercial settings, schools, etc.

SECONDARY CARE: Those health-service functions which deal with symptomatic stages of diseases which require moderately specialized knowledge and technical resources for adequate diagnosis and treatment and/or rehabilitation. Nursing practice in this area is primarily episodic in nature. Clinical facilities associated with the above include nursing homes, auxiliary hospitals, small general hospitals, etc.

TERTIARY CARE: Those health-service functions which deal with levels of disease which are seriously threatening the health of the individual and which require highly technical and specialized knowledge, facilities, and personnel. Nursing practice in this area is mainly episodic in nature. Clinical facilities associated with the above include highly specialized large teaching medical centres.

UNIVERSITY-BASED BACCALAUREATE PROGRAM: A generic program, usually four years in length, taken entirely within the university, wherein eligibility to write the registration examinations is concurrent with obtaining the baccalaureate degree.

Chapter 1

INTRODUCTION

INTRODUCTION

The Alberta Task Force on Nursing Education has been given the responsibility of examining nursing education in a broad context and of outlining programs at all levels with the goal of "providing Alberta citizens with a high quality system of nursing education and service" as outlined in the letter of January 24, 1975, from the Minister of Advanced Education to the Chairman of the Task Force.

Recognizing the significance of and vital contribution made by nursing personnel in the provision of health services, the Task Force focuses this study on nursing education programs, with the objective of ensuring Albertans the fulfillment of their health needs.

With this in mind the Task Force had as its general objective the preparation of a framework for the planning and coordination of nursing education in Alberta. In preparing this "framework," the Task Force examined the following issues, each considered an integral element of overall planning:

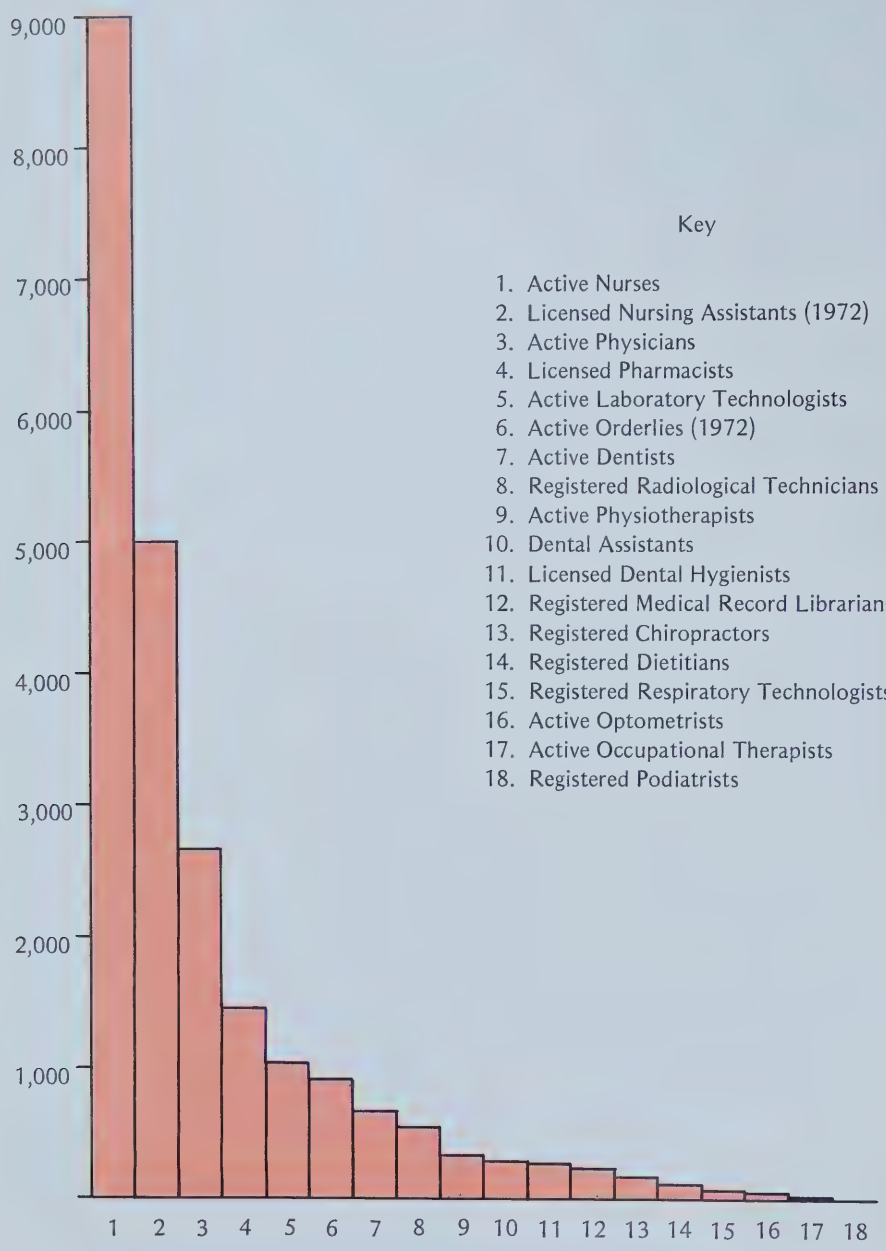
1. The current health-service needs of Albertans and their expectations of their health-care system;
2. The current system for delivering needed health services, and the practices involved;
3. Anticipated and desired changes or shifts of emphasis in the health-care delivery system, and related practices;
4. The role of nursing service within the health-care delivery system now, and as anticipated and desired in the future;
5. The specific categories or types of nursing personnel required for the current and evolving health-care system;
6. The competencies required of the various categories of nursing personnel to fulfill the role described in 4 and meet the requirements specified in 5;
7. The total educational system required to produce graduates with competencies described in 6;
8. The relationships of pre-service education, orientation, in-service education and further education within the total educational system described in 7;
9. The way of articulating the various parts of the educational system described in 7 and 8 to enable each member of the nursing labour force to achieve maximum level of competence, ensuring both personal satisfaction and enhanced quality of nursing service;
10. The mechanism for monitoring the educational system described in 7, 8 and 9, to maintain determined standards.

Nursing personnel constitute the largest component of the health-service labour force in the province. As Table 1 and Figure 1 demonstrate, the 1974 Canada Health Manpower Inventory reports, of eighteen health-occupational groups, nurses are the largest group, nursing aides second, and nursing orderlies sixth. The total of these three in 1973 was 14,624, constituting almost two-thirds of the total of all groups.

Table 1 also reveals that Alberta, compared to the nation as a whole, fares well in most categories of health workers. This, however, by no means assures all Albertans of adequate standards of health or health-care services. Gaps and weaknesses do exist, demanding study and improvements, as do challenges of meeting future health and nursing needs.

Figure 1

NUMBER OF HEALTH PROFESSIONALS FOR SELECTED CATEGORIES OF HEALTH MANPOWER, ALBERTA, 1973



Adapted from Canada Department of National Health and Welfare. Health Manpower Directorate. *Canada Health Manpower Inventory.* Ottawa, 1974: 167-172

Table 1

NUMBER OF HEALTH PROFESSIONALS FOR SELECTED CATEGORIES OF HEALTH MANPOWER, ALBERTA, AND RATIO EACH CATEGORY TO POPULATION, ALBERTA AND CANADA, 1973

Category of Health Worker	Number Alberta	Ratio of Population Alberta	Canadian Ratio of Category to Population
1. Active Nurses	8,962	1: 190	1: 180
2. Licensed Nursing Assistants (1972)	4,815 *	1: 344	1: 366
3. Active Physicians	2,526	1: 674	1: 618
4. Licensed Pharmacists	1,367	1: 1,273	1: 1,894
5. Active Laboratory Technologists	1,077	1: 1,580	1: 1,971
6. Active Orderlies (1972)	847	1: 1,954	1: 1,926
7. Active Dentists	611	1: 2,786	1: 2,851
8. Registered Radiological Technicians	497	1: 3,425	1: 4,558
9. Active Physiotherapists	309	1: 5,508	1: 7,278
10. Dental Assistants	254	1: 6,701	1: 13,585
11. Licensed Dental Hygienists	240	1: 7,092	1: 18,329
12. Registered Medical Record Librarians	207	1: 8,222	1: 12,393
13. Registered Chiropractors	203	1: 8,384	1: 14,901
14. Registered Dietitians	161	1: 10,571	1: 10,582
15. Registered Respiratory Technologists	155	1: 10,981	1: 32,804
16. Active Optometrists	141	1: 12,071	1: 14,420
17. Active Occupational Therapists	116	1: 14,672	1: 21,005
18. Registered Podiatrists	11	1:154,727	1:143,916
19. Active Audiologists & Speech Therapists	**	—	1: 45,339

*This figure does not necessarily represent "active" nursing assistants; some are licensed but not employed.

**The exact number of active audiologists and speech therapists in Alberta was not determined; it appears to be 50–100.

SOURCE: Canada. Department of National Health and Welfare. Health Manpower Directorate. *Canada Health Manpower Inventory*. Ottawa, 1974: 167-172.

Concern for nursing education in Alberta is really concern for the current and future health of Albertans. Not only should nursing personnel be effective and efficient in meeting the current nursing-service needs of the citizens of this province, they must also be responsive to changing health needs and problems. They must be innovative and proficient in promoting desirable and beneficial changes within their own practice in particular, and within the health-service system in general.

Therefore, this report examines the following topics: health needs and services in Alberta (Chapter 2); nursing in the health services (Chapter 3); categories of nursing personnel and their educational preparation (Chapter 4); the current nursing education situation in Alberta (Chapter 5); a system of nursing education for Alberta (Chapter 6); and monitoring the nursing education system (Chapter 7).

Chapter 2

HEALTH NEEDS AND SERVICES IN ALBERTA

HEALTH NEEDS AND SERVICES IN ALBERTA

To determine the nature of nursing-service needs in Alberta, the Task Force reviewed the evidence bearing on the health status of Albertans, their expectations of health services, and the discernible and desirable trends evolving in the province's health-service system.

THE HEALTH STATUS OF ALBERTANS

The Task Force approached its study of the health level of Albertans by attempting to define precisely the term "health" and by outlining the criteria for determining the health status of individuals. However, no satisfactory operational definition of health could be found, and it became necessary to revert to the usual health indices of infant mortality, life expectancy, incidence of disability, conditions requiring hospitalization, morbidity and mortality rates, and the reported incidence of notifiable diseases. The following words of Mills (1973:12) did add some clarity:

> The *real measure* [of health] is the ability of the individual to function in a manner acceptable to himself and to the group of which he is a part.
>
> Basic to the discussion of measuring health is the function of the individual in terms of his family, his work, his recreation, and his position in society.

Some aspects of health relate to such factors as age, economic status, education, and physical and social environments (Kohn, 1967). Two concepts which incorporate these factors are Lalonde's (1974) "Health Field Concept" and Robertson's (1973) "most important factors contributing to the quality of health of a people."

Lalonde's concept is composed of four broad elements: human biology, environment, lifestyle and health-care organization. The human biology component is defined as " . . . all those aspects of health, both physical and mental, which are developed within the human body as a consequence of the basic biology of man and the organic make-up of the individual" (p.31). This includes such factors as genetic constitution, the processes of maturation and aging, and the many complex internal systems of the body. The environment component refers to "matters related to health which are external to the human body and over which the individual has little or no control" (p.32). Lifestyle, the third category, is an aggregate of the individual's decisions and actions which affect health and over which one has more or less control. The final component, health-care organization, consists of the "quantity, quality, arrangement, nature and relationships of people and resources in the provision of health care" (p.32).

These four elements and their interrelations are considered important determinants of an individual's health status. They are similar to the following five factors, which Robertson (1973:30) suggests determine the quality of health of a people:

1. The genetic constitution of the population: the innate ability to withstand the stresses and strains of life;
2. The way of life: habits [such as] eating, rest and exercise, smoking, drinking, drugs;

3. The physical environment: housing, the purity of air and water;
4. The social environment: education, affluence and poverty, competition, love, hate;
5. Health care: the preventive measures, the promotion of health, the treatment of the sick.

The overall picture of the health needs and problems of Albertans, arising from an examination of evidence bearing on Robertson's and Lalonde's concepts, has implications not only for the health service, but also for the personnel functioning within it, and for the educational preparation of these personnel.

Genetic Constitution of the Population; Ability to Withstand Stresses and Strains of Life: Lalonde's Biology

Evidence bearing on the effects of life's stresses and strains on people was found in *Report 1970* of the Committee on the Healing Arts (Ontario, 1970), which estimated that 50 percent of the patients seen in general medical practice show symptoms of an emotional nature — anxiety, for instance (Lalonde, 1974: 61, 74). In a 1972 Alberta survey, Greenhill and Haythorne (1972) had three samples of the province's population report symptoms experienced over a two-week period. Five of twenty-five symptoms directly relate to emotional states and are reported in Table 2, as are the proportions of the 1,818 subjects in (1) a large and (2) a small urban centre, and (3) a rural area.

In contrast to the findings, over 90 percent of the three groups reported they considered themselves to be in good health (Edmonton 92.4 percent, Red Deer 94.7 percent and the rural area 90.2 percent). At the same time sizeable numbers of these people were taking non-prescribed drugs (for example, over 45 percent of each group were taking pain relievers). Greenhill and Haythorne wondered if the differential incidence found in those taking "digestive medicine" (11.4 percent in Edmonton, 9.1 percent in Red Deer and 6.4 percent in the rural area) could reflect the "price paid for urban living."

Other evidence of a population's response to the stresses and strains of life is the incidence of suicide. In Alberta, suicide is among the first four causes of death between the ages of 15 and 54, and ranks second between the ages of 15 and 34 (Smith, 1973). Male suicide rates in Alberta are higher than the national average.

Concerning the mental-health status of Canadians, statistics show the following:

1. Five to 10 percent of school children have an emotional or learning disorder requiring professional care.

2. One-third of all hospital beds and hospital days are for individuals with mental illness.

3. There is a significant increase in alcoholism and drug addiction, homicide and suicide, crimes, anxiety neuroses and depressive psychoses (Lalonde, 1974:25, 61).

4. Mental and emotional disorders are the largest source of disability in the Canadian population (Statistics Canada, 1974:58).

Table 2

SYMPTOMS OF AN EMOTIONAL NATURE REPORTED AS PERCEIVED BY SAMPLE ALBERTA POPULATIONS

Symptoms reported over a two week period	Sample Population: Edmonton No. = 579 %	Red Deer No. = 361 %	Rural No. = 878 %
Feeling anxious	15.2	13.5	11.2
Feeling jittery	12.4	10.6	7.1
Feeling tense	20.9	17.4	13.9
Feeling depressed	12.6	9.0	8.8
Having trouble sleeping	13.8	12.3	15.0

SOURCE: Greenhill, S. and D. Haythorne *Alberta Health Care Study: Health Care Utilization Patterns of Albertans 1968 and 1970 Final Report.* Final Report. Public Health Research Grant Project No. 608-7-106. Edmonton: Department of Community Medicine, University of Alberta, 1972:59

Physiological dysfunction and pathology are considered part of the body's reaction to the stresses and strains of life. In Alberta, during the period from 1970 to 1972, the circulatory system loomed highest in mortality rates followed by cancer, stroke, accidents, (more than twice as common in men as in women), respiratory problems, (such as pneumonia and influenza) and diseases of the arteries. Illnesses associated with the circulatory, digestive and respiratory system (in descending order) place the most time demand on hospital services. Injury and illness resulting from accidents, poisonings, and violence constitute the fourth highest time demand, with cancer the fifth (Statistics Canada, 1974:45).

In terms of frequency of demand on Canadian hospital services, the conditions with the ten highest rates per 100,000 population in 1970 were (in descending order): (1) genito-urinary system diseases; (2) accidents, poisonings and violence; (3) tonsillitis and adenoids; (4) heart disease; (5) all malignant cancer; (6) infectious and parasitic disease; (7) appendicitis; (8) diabetes mellitus; (9) kidney diseases; (10) chronic bronchitis (Statistics Canada, 1974:47).

Two causes of death peculiar to the neonatal period (anoxia and hypoxia in the case of both Canada and Alberta, and immaturity in the case of Alberta) are counted among the twelve leading causes of death among persons of all ages, according to Smith (1973). This fact has significant implications both for the life-support services offered the neonate, and for the detection of pregnant women at risk of losing their babies.

IMPLICATIONS FOR HEALTH STATUS. In the view of Task Force members, the foregoing discussion implies the need for:

1. More emphasis on promoting health, maintaining health, detecting those at risk, and preventing illness, as well as early diagnosis, prompt treatment, limitation of disability, and rehabilitation;

2. Continued research into the cause and prevention of health problems of genetic and biological origin;

3. Counselling, increased coordination and continuity of care for families sustaining such problems;

4. Continuing and increasing efforts to assist the handicapped in gaining maximum independence;

5. Concerted efforts to eliminate the high incidence of accidents and poisonings in this province.

IMPLICATIONS FOR NURSING PERSONNEL AND THEIR EDUCATIONAL PROGRAMS. As nursing personnel play a major role in all of the above, the implications for nursing practice and education are too numerous and varied to delineate in full. Several examples illustrate areas for nursing involvement:

1. Nurses' close proximity to patients and families places them in a good, if not unique, position to detect and intervene in situations of impending health problems, and also to collect research data and formulate hypotheses. Nurses can and should participate not only in health research relating to the cause and prevention of personal and environmental illnesses, but also in the assessment of the effectiveness of the nursing intervention.

2. Nursing duties often include counselling, teaching and motivating individuals and families in matters relating to health problems and appropriate therapeutic actions. Special knowledge and skills are required for these nursing roles.

3. Nurses could do much to eliminate the high incidence of accidents and poisonings — especially those in the home.

"Ways of Life" — Lifestyle

Individuals' habitual ways of responding to situations have considerable impact on their health status. Evidence suggests, for instance, in addition to biological responses, learned responses or habits can contribute to the development and progress of such conditions as high blood pressure, obesity, heart disease, cancer, alcoholism, criminal offenses, schizophrenia and suicide (Coleman, 1973). A number of serious health problems are created by individuals whose lifestyles contain self-imposed risks of illness or injury. These include drinking drivers, drivers who refuse to use seat belts, cigarette smokers, as well as abusers of alcohol and drugs, and the overweight. It has been estimated, for instance, seven hundred lives could be saved annually in Canada, if 50 percent of the people wore seat belts.

Admittedly, differences of opinion do

exist among specialists in various areas as to the effectiveness of certain activities in preventing illness and injury. Nevertheless, Lalonde has proposed that the following hypotheses "now appear sufficiently valid to warrant taking positive action" (1974:58):

1. It is better to be slim than fat.
2. The excessive use of medication is to be avoided.
3. It is better not to smoke cigarettes.
4. Exercise and fitness are better than sedentary living and lack of fitness.
5. Alcohol is a danger to health, particularly when driving a car.
6. Mood-modifying drugs are a danger to health unless controlled by a physician.
7. Tranquility is better than excess stress.

The habits or lifestyles of Albertans are basically similar to those of most Canadians, but some variations show reason for concern. Accidents, for instance, are the third leading cause of death for men in Alberta, the fourth for Canada as a whole (Smith, 1973). In fact, for the 1—44 age group, accidents are the leading cause of death in this province, according to Smith (1973:12), who also reports:

> Accidents and various forms of violence account for nearly two-fifths of the deaths in the age group 1—4, considerably more than half the deaths in the age group 5—14, more than four-fifths of the deaths in the age group 15—24, more than three-fifths of the deaths in the age group 25—34, and almost one-third of the deaths in the age group 35—44.

In the area of nutrition, a study of the knowledge, motivation and practices of Albertans leads to several observations and conclusions. It has been reported (Canada. The Department of National Health and Welfare, 1975), that (1) "overweight obesity and elevated cholesterol levels are health hazards of major proportions which warrant emphasis in preventive programs"; (2) the protein status of the elderly appears to be "only marginally adequate"; (3) there is reason for concern about the overall dietary intake of the elderly; (4) evidence supports a closer examination, and perhaps remedial action, relative to the Vitamin A intake of Alberta's Eskimo people; (5) many girls and pregnant women need larger amounts of calcium and Vitamin D; and (6) iron deficits are so widespread in the country that survey researchers conclude: ". . .procedures to reduce the deficiencies, such as improved enrichment practices and nutrition education programs should be considered."

IMPLICATIONS FOR HEALTH STATUS. From the limited review above and the information presented in the previous section, Task Force members emphasize again the need for a concerted effort by the public, health workers and government, directed towards mass health-education. Individuals and groups must come to realize how lifestyle can be a significant variable in the multiplicity of factors leading to illness and injury. Following such an acceptance, a second step in the education process concerns the altering of habits to those which promote rather than risk or hinder health.

Considerable evidence suggests many health workers have not fulfilled their responsibility in helping people improve lifestyles (Peitchinis, 1972). In fact, Paper No. 16 of the National Economic Conference (Health Services Committee, 1974) proposed a separate health-promotion system to

complement the existing health-care system.

The Task Force recognizes the implied need for:

1. Continued research into means whereby mental health can be promoted and mental illness prevented;

2. Increased application of what is known about the promotion of mental health and the prevention of mental illness by individuals, families, communities, and groups (day care workers, teachers, and employers), as well as health-service workers;

3. Research into more effective means of helping individuals to accept responsibility for their own health and to make necessary alterations in lifestyles to achieve a more healthy state.

IMPLICATIONS FOR NURSING PERSONNEL AND THEIR EDUCATIONAL PROGRAMS. To assume the responsibilities and duties of influencing lifestyles, nurses need more than a commitment to health promotion and maintenance and to illness prevention. They also require considerable knowledge on the psychology of human behaviour. In addition to classroom learning, nurses should be encouraged to join social scientists in further research on effective means of influencing human behaviour. As an example, one of the important determinants of individual behaviour is the socio-cultural groups to which one belongs — family, peers, classmates, professional colleagues and the like. Evidence suggests, for instance, adolescent peer-culture is a variable in the incidence of smoking and the use of alcohol and drugs by this age group (Lalonde, 1974:14).

Therefore, the Task Force sees the following implications for nursing service and education:

1. Helping individuals come to appreciate how their lifestyles (eating, rest and exercise, drinking and drugs) affect their health;

2. Motivating people to alter lifestyle detrimental to health;

3. Supporting and helping individuals in lifestyle changes, so they may adopt corrective action and/or participate in appropriate intervention to promote mental health and prevent mental illness;

4. Applying known principles of the behavioural sciences to nursing practice;

5. Participating in research to determine effective means of bringing about change in behaviour related to health;

6. Working with groups such as day care workers, teachers and employers, to help them become more effective in promoting mental health, in detecting indications of possible deviant behaviour, and in providing for appropriate intervention;

7. Increasing the ability of individuals and families to prevent and cope with crises.

Social Environment and Health

Robertson (1974) considers such issues as education, affluence and poverty, competition, love and hate, to be aspects of the social environment. This seems consistent

with the view that people, and their intrapersonal as well as interpersonal relationships, are the essence of one's social environment. All personal interactions in family, home, school, work, recreational and religious activities can have a bearing on individual and group health. For example, evidence continues to show the social environment of the home is a significant variable: in the emergence of a health problem; in the views held concerning health as well as illness and its treatment; and in the utilization families make, as well as the demands they impose, upon health services (Crawford, 1971). The same is true of the social environment associated with school, work, church and recreational activities. All contribute positively or negatively to the fulfillment of the basic human requirements necessary for the development and maintenance of health.

Basic requirements also include the meeting of needs related to normal physiological function and to feelings of safety, in both the physiological and psychological realms. Human beings need self esteem, love and affection. In addition, many suggest healthful living requires meeting the needs to know and understand, to appreciate beauty, and to fully utilize one's potential as an individual.

The importance of an adequate diet and sufficient emotional, perceptual, intellectual and even psychomotor stimulation in the healthy development of the child, is generally known. Some suggest there are specific developmental tasks to be accomplished as one progresses through life. People in one's social environment can do much to enhance or hinder development. Consider, for instance, the battered child syndrome, the constantly "nagged" husband, the worker who has to function above or below his or her level of competence, the home with constant tension.

Alberta should be aware of its divorce rate, 224 per 100,000 people, while the national average is 137 (Statistics Canada, 1974:19). This provincial divorce rate may imply a higher incidence of unhappy home environments, an accumulation of persistent minor stresses, and harmful effects on the health of those involved. Perhaps it also suggests an increased number of single parent families needing support of various kinds.

For many people, yet another element influencing health is the considerable time spent in the social environment of work. The results of one study point to job dissatisfactions and frustrations as a possible factor contributing to heart attacks (Coleman, 1973:175).

The so-called social diseases, syphilis and gonorrhea, remain a health problem of some magnitude. Although the incidence of syphilis in Canada has remained fairly constant in recent years, that of gonorrhea has increased considerably (Statistics Canada, 1974:43). This is also true in Alberta. Other communicable and notifiable diseases reported during the period October–December, 1973 in Alberta, were, in rank order: streptococcal sore throat and scarlet fever (counted as a single entity), measles, infectious hepatitis, salmonellosis, rubella and bacillary dysentery. The increase in incidences reported for some of these diseases and the failure to eradicate diphtheria demand

increased vigilance in both case-finding and preventive measures.

IMPLICATIONS FOR HEALTH STATUS. The above data imply an apparent need for:

1. Increased effort directed toward promoting happy and effective family life, and toward helping individuals learn how to communicate with each other more effectively and with empathy;

2. More effective "family life education", and programs to increase "effective parenting";

3. More effective service to particular age groups in society: the adolescent, middle aged and elderly all have special concerns and need special attention;

4. Increased efforts by individuals and groups as well as health workers, to increase the effectiveness of various social environments in promoting and maintaining good health, in detecting those at risk of illness, and in ensuring prompt intervention to prevent the deterioration of health or the onset of illness;

5. Research into the ways and means social institutions (such as trade unions, industry and commerce, government, schools, religious organizations, family, recreational organizations) can contribute to health promotion and maintenance and illness prevention;

6. More cooperative and effective communication and coordination among the various health programs serving people in home, school, and the worlds of work, religion and recreation.

The school health program, for instance, must attempt to integrate its foci and aims into the overall community health program, which includes individual, family, community and occupational health services. The school health program, meanwhile, covers the following aspects: promoting and guarding the students' and teachers' health; the teachers' role in enhancing the health of students and in detecting problems in students' health; the coordination of the work of the school health team; maintaining a healthful school environment, both social and physical; and health education in institutions.

Similar kinds of questions could be asked of health services offered to participants in the diverse worlds of work. The Task Force found the contribution of Dorothy L. Smith (1975) most valuable. Mrs. Smith, a nurse in Edmonton, made a strong case for the integration of occupational health services with community health services. In addition she delineated the kinds of knowledge and skills baccalaureate nursing graduates must have to function competently in comprehensive occupational health services. These are presented in Appendix A:1.

Attention is drawn also to the *Report* (Alberta Industrial Health and Safety Commission) submitted to Alberta's Lieutenant Governor in Council on 31 January, 1975. The Task Force urges implementation of its recommendations on such issues as the education of workers in health and safety practices and the nature and responsibility of occupational health services (see Appendix A:2).

IMPLICATIONS FOR NURSING PERSONNEL AND THEIR EDUCATIONAL PROGRAMS.

1. Greater emphasis on the person with "dis-ease" versus disease entities as such;

2. More attention to anticipatory guidance for individuals and families in terms of life-cycle changes;

3. Greater consciousness of the political and socio-cultural influences on health and illness;

4. More recognition, in the form of social and economic rewards, for the contributions of nurses working outside the hospital setting;

5. More equitable balance between in-hospital and out-of-hospital practicum experience for students.

Physical Environment and Health

Although significant strides in recent decades have made the physical environment more conducive to healthful living, these efforts fall far short of being complete or acceptable. Many hazards remain hidden, unrecognized or untouched, and there is a need for continuing concern and increasing effort in diminishing or eliminating these dangers. A healthy physical environment involves such concerns as: safe supplies of water, food and milk products; safe cosmetics and other chemicals used for personal reasons; sanitation in public places; effective disposal of wastes and hazardous materials in homes and at work; control of air pollution, radiation hazards, microbial contamination; adequate housing; noise abatement; accident prevention.

IMPLICATIONS FOR HEALTH STATUS. The above discussion implies the need for:

1. Additional, adequate housing facilities to reduce over-crowding, lack of privacy, and contagious diseases;

2. Upgrading of rural sanitary facilities;

3. Vigilance in maintaining current health-code standards to physical environments (*e.g.,* restaurants, schools), and in some instances a need for more stringent standards;

4. More area-wide planning and control measures related to air and water pollution;

5. Increased effective efforts in home, school, and work-safety programs;

6. Better monitoring of foodstuff for pollutants and additives.

IMPLICATIONS FOR NURSING PERSONNEL AND THEIR EDUCATIONAL PROGRAMS.

1. Greater nursing involvement in the assessment and elimination of hazards to improve home safety, selection of safe food stuffs and home supplies, the disposal of waste and dangerous materials;

2. Increased nursing influence on safety measures and programs relating to industry, transportation and recreation;

3. Greater emphasis on "continuing to

learn" by: keeping abreast of research on environmental hazards, remedial actions and preventive measures; identification of areas needing investigation; and participation in the research itself;

4. Commitment to inform and warn governments and the public of conditions, products and practices hazardous to the physical environment (and thus health) and to pressure for remedial action.

Health Services in Alberta

The health system is another factor Robertson (1973) and Lalonde (1974) consider important in the determination of the quality of health of a people.

Although the Task Force does not wish to elaborate upon the obvious, members do desire to record some of the health-and-illness assumptions accepted, before reporting a rough assessment of the current health service system in the province.

1. Health and illness may be considered on a continuum from the highest state of "wellness" to the most severe disability.

High level wellness (health) ⟷ Illness.

2. Health services range from the most highly individualized to society-based.

Individual ⟷ Family ⟷ Community.

3. Health services span the life cycle of individuals and populations.

Pre-natal existence ⟷ Birth ⟷ Death

4. Levels of health services can be placed along a continuum of primary, secondary and tertiary prevention. Figure 2 demonstrates the relationship of the health-illness continuum (pre-pathogenosis ⟶ pathogenosis) in terms of types of interventions or preventive measures most appropriate to various population groups.

5. Health workers attempt to assist individuals, families and communities at whatever point they are located on these continua.

6. Basic to understanding the above conditions and processes is knowledge of human functioning, as individuals and groups.

With these basic assumptions in mind, the Task Force looked at present health services from two points of view: facilities and the nursing component.

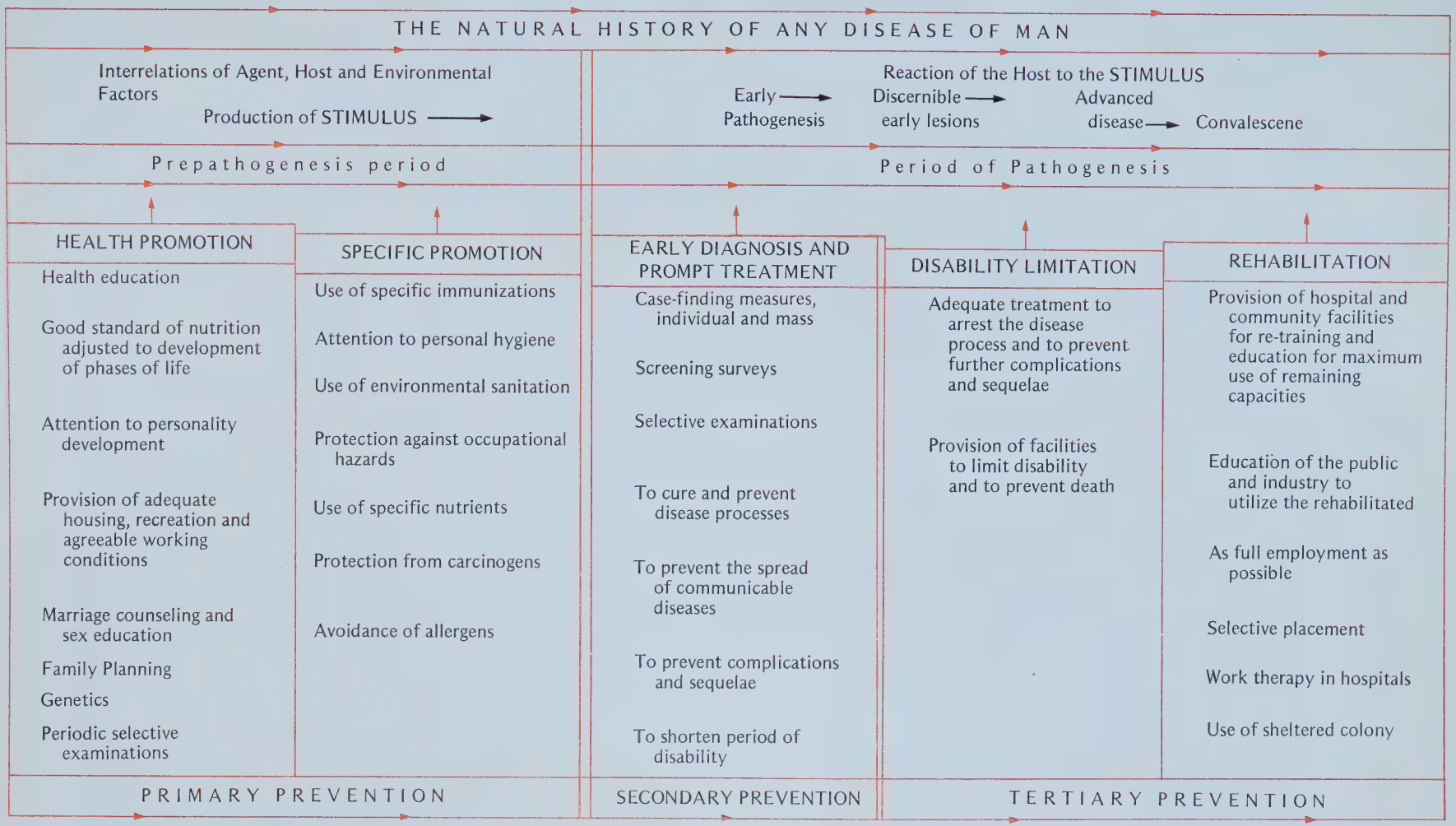
The 1973 Annual Report of the Alberta Hospital Services Commission reported the following numbers and types of health-service facilities:

Health Service Facility	Number
1. Approved general hospitals	119
2. Federal hospitals and nursing stations	8
3. Contract general hospitals	2
4. Special rehabilitation centres	2
5. Auxiliary hospitals	29
6. Nursing homes	75

The same report notes that facilities one through five constitute a ratio of 9.5 hospital beds to every 1,000 persons. Adding nursing homes brings this ratio to 13.1 per 1,000. The Canadian national average is 7.1. Recognizing the majority of health needs are not related to institutional care, one might question the attention given to inpatient treatment of the

Figure 2

LEVELS OF APPLICATION OF PREVENTIVE MEASURES


THE NATURAL HISTORY OF ANY DISEASE OF MAN
Interrelations of Agent, Host and Environmental Factors
Production of STIMULUS
Reaction of the Host to the STIMULUS
Early Pathogenesis
Discernible early lesions
Advanced disease
Convalescene
Prepathogenesis period
Period of Pathogenesis
HEALTH PROMOTION
Health education
Good standard of nutrition adjusted to development of phases of life
Attention to personality development
Provision of adequate housing, recreation and agreeable working conditions
Marriage counseling and sex education
Family Planning
Genetics
Periodic selective examinations
SPECIFIC PROMOTION
Use of specific immunizations
Attention to personal hygiene
Use of environmental sanitation
Protection against occupational hazards
Use of specific nutrients
Protection from carcinogens
Avoidance of allergens
EARLY DIAGNOSIS AND PROMPT TREATMENT
Case-finding measures, individual and mass
Screening surveys
Selective examinations
To cure and prevent disease processes
To prevent the spread of communicable diseases
To prevent complications and sequelae
To shorten period of disability
DISABILITY LIMITATION
Adequate treatment to arrest the disease process and to prevent further complications and sequelae
Provision of facilities to limit disability and to prevent death
REHABILITATION
Provision of hospital and community facilities for re-training and education for maximum use of remaining capacities
Education of the public and industry to utilize the rehabilitated
As full employment as possible
Selective placement
Work therapy in hospitals
Use of sheltered colony
PRIMARY PREVENTION
SECONDARY PREVENTION
TERTIARY PREVENTION

Adapted from Leavell, Hugh Rodman, and Clark E. Gurney. *Preventive Medicine for the Doctor in His Community, An Epidemiological Approach.* New York: McGraw Hill, 1965, by the Columbia University School of Public Health

sick versus outpatient treatment, home treatment and preventive measures. Using Garfield's (1970) construct one could extrapolate that there is a greater emphasis placed on services to the "sick" rather than the early sick, worried well, or well components of the population.

In addition to the facilities listed above, there are 29 health units or health centres throughout the province, and several provincially operated institutions and voluntary-association facilities serving the mentally ill and mentally retarded.

The number of mental health centres in the province is increasing. However, Task Force members are concerned over the developing fragmentation of the health-care delivery system resulting from the separation of mental and physical health services in the community.

Of course, the health-service system is augmented by all the office and clinic services of physicians and other health workers; by occupational health centres in industry, business and other establishments; and by voluntary operated services (some of which also have government grants such as the Victorian Order of Nurses). There are also hosts of voluntary agencies oriented to particular health problems such as blindness, heart disease, mental health, and kidney disease. Nursing personnel function in many of these areas of service: hospitals (general, special, psychiatric, rehabilitative and auxiliary); nursing homes; local health centres; industrial and occupational health centres; private homes; senior citizen lodges; schools and other educational institutions; clinics and other health services, such as ambulatory care units.

A classification and comparison of areas in which nurses are employed in Alberta and Canada follows (Canadian Nurses Association, 1975:14).

Area of Employment	Alberta Total = 9,127 %	Canada Total = 118,897 %
Hospital or other institution	83.2	83.3
Public Health (including school health)	6.9	6.7
Office (physician/dentist)	4.0	2.8
School of Nursing	3.4	3.3
Occupational Health	1.3	1.6
Private Practice	1.0	1.9
Other	0.2	0.4

The Canadian Nurses Association (1975) reports 4,975 licenses were issued to nursing aides in Alberta in 1973, but a classification of this figure was not available. The Alberta Association of Registered Nursing Orderlies lists 734 orderlies registered in 1973, with the majority employed in hospitals or other institutions. By April 1975, a total of 313 psychiatric nurses were registered with the Psychiatric Nurses' Association of Alberta. Of this number 77.64 percent are employed in hospitals or other institutions, 6.39 percent in public health, and 15.77 percent come under the "other" classification.

From the discussion above it becomes apparent that the current health-service system, in manpower as well as facilities, ascribes a higher priority to therapeutic care for acute illnesses than for health promotion, health maintenance, and rehabilitation related to chronic illness. Few nurses are employed in ambulatory-care settings, where the major health needs are found, and the delivery costs are lower.

The Task Force does recognize, however, a comparison of cost factors must take into consideration the huge expenditures incurred by hospitals for expensive but vital programs (such as renal dialysis). As well, increases in the volume and sophistication of services, inflation, and wage and benefit increases have all helped to drive up hospital costs.

IMPLICATIONS FOR HEALTH STATUS. With respect to health-care services, the Task Force identified the need for:

1. Increased quality of care for geriatric cases, patients transferred from the psychiatric hospital to nursing homes, and the chronically ill;

2. Increased ambulatory rehabilitative services;

3. More adequate service to inner-city populations and the Indian and Metis people;

4. Improved health service in particular geographical areas: isolated regions in general and specifically the northern section of the province;

5. Outreach services to those sections of the population, which for a variety of reasons, do not use current health services;

6. Prevention of occurrence of crisis situations and prevention of progression of acute and chronic situations, both psychological and physiological, to individuals, families and communities;

7. More, better, and easier access to crisis services, including an ongoing learning process in preventing crises, and follow-up to ensure learning takes place;

8. Increased emphasis on improving the effectiveness of health-service personnel, thus decreasing health-service costs;

9. Development of criteria and tools by which the efficiency and effectiveness of the health industry and its workers can be assessed;

10. Greater fiscal support and personnel remuneration in the areas of health promotion, health maintenance, and disease prevention;

11. More integration of mental health services into the overall health-care delivery system.

IMPLICATIONS FOR NURSING PERSONNEL AND THEIR EDUCATIONAL PROGRAMS.

1. A re-structuring of nursing practice and education, putting both more in line with a health-care model rather than a medical-care model;

2. A more active role for nurses in the fostering of an acceptance of the need for concerted effort by the public and health-service workers, if the health level of Albertans is to be improved;

3. A re-evaluation in terms of nursing education priorities of the current arrangements and effectiveness of primary, secondary, and tertiary clinical practice facilities for students.

CONSUMERS' EXPECTATIONS OF THEIR HEALTH SERVICES

The question arises, of course, what does the public expect of the health service? Although they have long expected the best of medical services when ill, only recently has the public begun to articulate some specific expectations of its health service. In its April 1974 issue, for instance, *Canadian Consumer,* a publication of the Consumers Association of Canada, printed and discussed "Consumer Rights in Health Care." The Task Force is in general agreement with this "bill", which is presented in Appendix A:3. However, members thought it should have contained some reference to the consumer's responsibility for the promotion and maintenance of one's own health.

In general, the Task Force takes the position that Albertans have a right to expect the following from their health service:

1. Access to primary care near home at all hours, transportation to specialized services away from home if required, and "outreach" emergency services where necessary;

2. Adequate assessment of health-illness risks (physical, emotional and mental);

3. Immediate and continuous care for health-illness problems;

4. Educational services to promote health;

5. Intervention to prevent illness.

These are fairly consistent with the Background Study for the Science Council of Canada on health care in this country. This study states what a person can reasonably expect in the way of health care:

> A person should have access, without barriers of any sort, to a coordinated system of health care which embraces the full range of facilities of high quality, operated considerately and efficiently. There should be, within the system, continuity of care and as much freedom of choice (of doctor, dentist, service or institution) as is compatible with the smooth operation of the service (Robertson 1973:50).

The Nursing Service Department, Foothills Hospital, Calgary, Alberta, initiated a study entitled, "The Expectations and Perceptions of Consumers, Nursing Staff and Medical Staff Regarding Nursing Care in a General Hospital" (Peitchinis, 1971).

Statistical analysis of patient respondents' data revealed the following (Peitchinis, 1972): patients expected, from hospital staff, interest in them as people not just patients, skill in treating them, and information regarding their condition. Patients felt they had a right to participate in decisions regarding their care, and to have information about home care. They also thought they had a right to courteous greetings, an orientation to hospital and the hospital experience, and ongoing information on their care and condition.

It seems more people are complaining about: difficult access into the system, lack of coordination within the system, and poor continuity of care (Robertson suggests these are some of the faults of the health system). Greenhill and Haythorne (1972) found Albertans objected to long waits for attention. The data also suggest urban Albertans' expectations of their health service *may* be higher than rural dwellers, and urbanites *are* less satisfied with health services than the rural population.

Certainly easy access and effective service are not only desirable but also necessary in the health service.

DESIRABLE AND DISCERNIBLE TRENDS IN HEALTH SERVICES

In relation to emphasis on both easier access to health services and effective service, attention is drawn to national, provincial, and international trends toward the development of primary care centres, often called "health centres" (Canada's "Hastings" Report, Ontario's "Mustard" Report, British Columbia's "Foulkes" Report, Quebec's "Castonguay" Report, Manitoba's White Paper on Health Policy, and recent revision in the British Health Service). A study by the Centre for Educational Research and Innovation (1975) entitled *New Directions in Education for Changing Health Care Systems,* sees the *key* issue in the future of health policies as the need for improved and expanded primary-health care. Primary care has been described as including:

> . . .not only those services that are provided at first contact between the patient and the health professional, but also responsibility for promotion and maintenance of health and for complete and continuous care for the individual, including referral when required. . .
>
> The primary care groups can be described organizationally as a number of health professionals grouped together to meet primary health needs in a given geographic area on a continuous (twenty-four hour) basis. The organizational grouping does not necessarily imply a common physical location, but it should make possible a more effective utilization of the skills of health professionals within the groups and provide for a range of health services that are available, accessible and continuous.
>
> The functions of health personnel in the primary care groups include prevention, health promotion, health maintenance, consultation, education, diagnosis, treatment and rehabilitation (Ontario: Health Planning Task Force, 1974:11).

In addition to trends toward primary care as described above, there is generally: increased emphasis on health promotion and maintenance, and on community and home-based care; an increased interdisciplinary

health-team approach to health service delivery; and increased sophistication and specialization in acute care settings.

The Task Force sees the following trends as desirable, and wishes to see more emphasis placed on them in Alberta:

1. Increased integration of various aspects of health services, i.e. more comprehensive care, especially in terms of "health" and "mental health";

2. Increased communication and coordination among components of the health service, and thus better continuity of care;

3. Increased emphasis on health-promotion, health-maintenance, identification of population at risk of illness, intervention to prevent illness, disability limitation and rehabilitation;

4. More effort directed to promoting citizens' assuming responsibility for their own health;

5. Research into effective means of helping individuals change their lifestyles to those conducive to health promotion and maintenance;

6. Improved service to particular population groups: the elderly, including those in nursing homes; persons transferred from psychiatric and other hospitals to nursing homes; and those in isolated areas;

7. Avoidance of unnecessary, expensive duplication of health services;

8. Increased fiscal resources to provide more adequate preventive-health services to all age and social groups in the population, and to population groups with special health problems;

9. Improved working relationships among health workers (the inter-disciplinary team);

10. Endorsement of the following priorities, set out by the Health Services Committee (1974):

(a) The health education of the young,
(b) The design of incentives for adults (individually and organizationally) to avoid self-imposed risks,
(c) The study of the ecology of health care, consumption and the pattern of services utilization,
(d) The development of programs to deal with high risk populations.

This chapter has indicated many direct and some indirect implications for nursing service, and consequently for nursing education. It should also be apparent from the previous discussion that the nursing role within health care is seen in a broad context. Within such a context, nursing personnel, practising to their potential, can meet a large segment of the health needs of the people of this province.

NURSING IN THE HEALTH SERVICE

The discussion in the previous chapter pointed to the need for increasingly effective efforts on the part of citizens and health-service personnel to enhance the positive health status of the people of this province, to maintain health at the highest level possible, to detect groups at risk of illness and prevent illness, to ensure early diagnosis and prompt treatment when illness strikes, to limit disability associated with illness, to ensure maximum rehabilitation of those afflicted by illness or injury and to promote a peaceful death for those who have no other prognosis. The implications for nursing practice and education of these health-status factors suggest a unique and evolving role for nursing personnel within the health service.

THE "UNIQUE" ROLE OF NURSING

Keeping in mind that nursing personnel are the largest sector of the health labour force, the Task Force turned its attention to defining the role of nursing in terms of its specific and/or unique contribution to health services.

Although there is no paucity of definitions proposed for nursing, one of the few that discusses the "unique" function of "the nurse" is that of Henderson (1966:15):

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls; of this she is master.[1]

In addition to this role, according to Henderson, the nurse assists in providing the care prescribed by the doctor for the patient. She also works with and assists other members of the health-care team in all aspects of health care. However, Henderson asserts, this unique function should not be jeopardized by any member placing heavy demands on another, or by performing non-nursing activities to the neglect of the nurse's special duties.

Henderson makes another important point: the patient is the central figure in the health-care team and must be actively involved in his own care. This implies mutual involvement by both the patient and health-care worker. If nursing practice is to be effective, the nurse has to believe in the patient's ability to solve his own problems and in his right and responsibility to make his own decisions. One aspect of the professional's education, all too readily overlooked, is the requirement to interact with the consumer as a colleague.

Henderson's definition, of the unique contribution of the nurse does not discriminate between what is referred to in the nursing education literature as "professional", "technical" and "vocational" nursing practice. Generally speaking, the first category is a university graduate, the second a graduate of a diploma or associate-degree granting institution, while vocationally-prepared personnel are assistants and/or aides to those with a technical or professional education. In considering these categories, Task Force members preferred to think in terms of "professional" and

[1] In her keynote address at the 50th Anniversary Convention of the Registered Nurses Association of Ontario in Toronto, June 12, 1975, Henderson reiterated her 1966 definition and indicated how it is still appropriate today.

"para-professional" nursing personnel, the former being those prepared at the current diploma level and beyond, while the latter are those prepared as "nursing assistants".

During its examination of the specific role of nursing in the health services, the Task Force gave consideration to the "definition of nursing" and the "functional definition of nursing" proposed by the Alberta Association of Registered Nurses in its "Position Paper on Nursing" (March, 1975:3–4):

> Definition of Nursing
>
> The practice of professional nursing as a Registered Nurse means the performance for compensation of any act, the goal of which is TO ASSIST the individual and family, regardless of the practice setting, to achieve their potential for health. Such practice involves a process which is a systematic, goal-directed, individualized approach to CARE.
>
> In the practice of professional nursing, within the limits of institutional policy and the law, the nurse has an independent role consisting of assessment, planning, implementation and evaluation of nursing care; a dependent role consisting of the implementation of treatment prescribed and delegated by a licensed physician; and a collaborative role with members of the health team, the family and other community representatives.
>
> A Registered Nurse may also perform additional acts under special conditions requiring special education and training which are recognized jointly by the medical and nursing professions and the public as proper to be performed by a professional nurse under such conditions.
>
> Functional Definition of Nursing
>
> The practice of the Profession of Nursing consists of those functions which, in collaboration with the client and other health workers, have as their object to assist the individual and his family to meet their immediate needs for care and to achieve their potential for self-direction for health. Such functions include:
>
> (i) observation, assessment and analysis to contribute to diagnosis;
> (ii) planning, implementation and evaluation of nursing care;
> (iii) case finding;
> (iv) health teaching;
> (v) health counselling;
> (vi) the implementation of treatment prescribed by a licensed physician; and
> (vii) the systematization and development of nursing knowledge.

These definitions refer to the issue of independence-dependence in nursing practice. They also imply the role of nursing is changing and will probably continue to do so.

INDEPENDENT, INTERDEPENDENT AND DEPENDENT ROLES IN NURSING

In their practice, nursing personnel function on a continuum of independent, interdependent and dependent roles. One of the main determinants of the location of particular nursing practices along this continuum is the degree to which nursing personnel independently make judgements and initiate action relative to the individual's health and treatment needs. Among the chief

factors that determine the extent to which nursing personnel exercise such judgements are: the nature of the information on which decisions are based; the knowledge and expertise of nursing personnel; the availability of other health-service personnel, particularly physicians; the confidence and trust health-service workers have in each other's ability; and the peculiarities of the particular situation.

There are, of course, different levels of decision-making among different categories and types of nursing personnel. For instance, the realm within which the registered nurse makes decisions regarding nursing action is broader than that of the certified nursing aide or registered nursing orderly. Differential levels of knowledge and expertise within the registered-nurse group dictate differential levels in their spheres of judgement. Nurses who function in coronary care units, for instance, should be able to recognize abnormalities in electrocardiograms and to take immediate corrective action. Nurses in other areas may not be expected to have such expertise. In general it is agreed, other things being equal, the more education and experience nursing personnel have, the less the amount of external constraint that is placed upon their decision-making.

Specific examples of independent functions include teaching and counselling in relationship to wellness and such psycho-social areas as growth and development of individuals and families. Some nurses in the United States have set up their own private practice as independent practitioners and they give initial and/or continuing care to the person, assist the person in self-care, or refer the individual to another agency or professional group (either within nursing itself or outside of nursing). Legally these nurses are responsible for their own practice and accountable to the clients and their families.

The interdependent role in nursing practice can refer to decisions made in consultation with other health workers, as well as to decisions made by nursing personnel in the course of their supervision of and participation in observations and treatments prescribed by others. The latter may be nursing care determined by more expert and experienced nursing personnel, therapy instituted by the physician, or treatments and therapies undertaken by other health workers such as physiotherapists, occupational and recreational therapists, nutritionists and dietitians, psychologists and social workers. It seems in a number of instances the demarcations separating the independent, interdependent and dependent nursing roles are blurred.

The dependent role in nursing practice refers to nursing practice situations in which nursing personnel function within the dictates of others. These can be decisions of the more competent nursing personnel, requirements prescribed by physicians, and the policies of the agency within which nursing staff function. Increasingly it is recognized that nursing personnel should not follow blindly the directions or orders of others. They have a responsibility to question or challenge orders or directives, which in their view are not in the best interests of patients.

Another way of conceptualizing the degree of independence and dependence is noted by Tinkham and Voorhies (1972:173):

1. Assisting activities: these facilitate the work initiated by another person who is responsible for the outcome. Examples are the nurse assisting a physician with a physical examination, or administering medications ordered by the physician.

2. Complementing activities: these are initiated by another person, but the nurse adds a specific nursing dimension for which she has responsibility. Examples are teaching a person with diabetes how to plan his diet which has been ordered by the physician, or planning and arranging for school health examinations.

3. Initiating activities: the need is recognized by the nurse who initiates action. Examples would be identifying nursing needs and planning the necessary nursing action to alleviate the need, i.e., helping the family cope with its health problems; or planning and conducting nutrition classes for obese teenagers.

At the time of writing, registered nurses in Alberta are considering definitions of these independent-dependent roles as proposed by their Association. These definitions are reproduced in Appendix B:1. Similar definitions were presented to the Task Force in a paper prepared by the directors of the province's diploma schools of nursing.

THE "GREY AREA" BETWEEN NURSING AND OTHER HEALTH DISCIPLINES

Involved in the issue of independent, interdependent and dependent roles in nursing practice is the issue often referred to as the "grey area" between nursing and medicine, and between nursing and other health disciplines.

In this area there are, of course, differences of opinion on whether particular decisions and activities constitute medical, nursing or other allied health disciplines' practice. Included among allied health disciplines are such groups as social workers, psychologists, physiotherapists, occupational therapists and respiratory technologists. As knowledge, technology and expertise increase, areas of function overlap, interchange and shift within and among various groups of health workers. Those taking on new and/or added responsibility must be aware of the risks involved, since legislation is usually so general in nature as to afford little, if any, protection. Legal authority lags behind changes in practice.

To assist in resolving these issues, provincial nursing and medical associations, in cooperation with provincial hospital associations, publish periodic statements, such as those available in Alberta entitled *Guidelines for Medical-Nursing Responsibilities* (AMA, AARN, AHA, 1972).

There are occasions, particularly in very specialized health-care agencies, where the level of patient service is more sophisticated than that reflected in the aforementioned Guidelines. In such instances, particular groups of physicians and nurses have sometimes come to regard the responsibilities involved as "shared" responsibilities. In some agencies the specific physicians and nurses concerned have determined, with the concurrence of the hospital's administrative officials, the nature and conditions of these shared responsibilities.

Schlotfeldt (1973:769) summarizes in an incisive manner the issues related to role

delineation and differentiation. She states:

> The nurse's *primary* intellectual concern, and functions related thereto, is that of helping each person attain his highest possible level of general health; the physician's *primary* intellectual concern, and functions related thereto, is the diagnosis and treatment of illness.
>
> Both physicians and nurses are concerned ultimately with the health of people. The physician's *practice* focus, however, is on differentially diagnosing and treating pathologies through the selective application of medical science and the discriminating use of available medical strategies. The nurse's *practice* focus is on assessing peoples' health status, assets, and deviations from health, and on helping sick people to regain health and the well or near-well to maintain or attain health through the selective application of nursing science and the use of available nursing strategies.

Lynaugh and Bates (1973:68) add another dimension to the issues relating to the collaborative role:

> If the nurse and physician believe that patients require education, counselling, advocacy, comfort, and support in conjunction with diagnosis and therapy, then the effort to understand one another is worthwhile. Similarly, each need not only to accept responsibility for his own professional sphere, but also to understand and accept the goals of his colleagues. If the comprehensive view of patient care is not a strongly held value, then real communication about patients probably will not occur.

Health workers who function within an agency are protected by the agency's liability insurance, as long as their function is within the terms of reference specified by that agency. If the nurse is not guilty of illegal acts or malpractice, the employing agency protects her from liability in the so-called "grey areas" of practice in that agency. In addition, nurses in the Alberta Association of Registered Nurses have liability insurance coverage as a benefit of membership.

Nurses must be certain, when taking on other or added responsibilities, that they do not deprive patients of their right to, and their assurance of, quality nursing service. There are many instances of large numbers of nurses spending too much time on clerk and unit-manager activities, and on duties related to physiotherapy, respiratory technology, pharmacy and general hospital administration, especially during evenings, nights and weekends.

"GREY AREAS" WITHIN NURSING SERVICE

An indication of the "grey area" within nursing practice is shown by the surveys of the Alberta Certified Nursing Aide Association, regarding activities this group has been asked to assume, and for which its members do not consider themselves prepared. The report of the Alberta Hospital Association and Alberta Association of Registered Nurses Survey, "Roles and Responsibilities of Certified Nursing Aides", (January 1975), initiated at the request of the Alberta Certified Nursing Aide Association, corroborates this. The study also reveals discrepancies between what aides, their employers, and those responsible for their education perceive as being included in aides' initial preparation.

Though Task Force members were concerned with the tendency for some employers to require more from nursing aides than they have been trained to do, members were even more concerned with evidence of considerable nursing care being provided in auxiliary hospitals and nursing homes by individuals trained-on-the-job. Apparently much of this training is minimal. A report to the Task Force from the Progressive Extended Care Division of the Edmonton Regional Hospital Conference (1975) stated that 80 to 90 percent of the nursing staff in such facilities are "untrained auxiliary nursing personnel". When the skill components of the educational programs experienced by certified nursing aides and registered nursing orderlies were compared with job descriptions of "hospital assistants" and "nursing home aides", the skills were almost identical with regard to the care of the adult. There certainly appears to be unwarranted substitution of nursing personnel downward, from the certified nursing aide and registered nursing orderly to relatively untrained personnel.

THE "EVOLVING" ROLE OF NURSING

In addition to the "transfer of function" phenomenon described above, nursing practice adjusts to meet the changing needs and problems of health-service consumers. Nursing personnel may be instrumental in bringing about new and innovative changes which they have found or consider as leading to more effective outcomes for the people they attempt to help.

The Task Force noted that the Alberta Association of Registered Nurses in its *Position Paper on Nursing* (1975:9–11) discussed eleven "Future Directions" in nursing. As these reflect the considered opinion of the professional association, they are presented here as likely indications of the "evolving" role of nursing:

1. Personal Health Goals. Nurses will work more intensively with individuals and families, assisting them in achieving their goals for health.

2. The Developing Health Care System. The involvement in all facets of the health-care system places nursing in an ideal position to contribute to its overall development and progress . . .

3. Interdisciplinary Approaches to Care. There will be greater emphasis on the collaborative role of nursing with other health disciplines in planning, providing and evaluating comprehensive health care.

4. The Decisional Role of the Nurse. There will be an increasing commitment to knowledge and to the extension and organization of nursing knowledge. Nursing will make more independent and interdependent judgements in an increasing number and variety of health situations, notably prevention, acute, convalescent and long-term care, and in providing for continuity of care throughout the health continuum.

5. Nurses in Primary Care. As an initial contact person the nurse will be increasingly responsible for case finding, case screening and counselling toward conservation and promotion of health.

6. The Preparation of Nurses for Administration and Educational Leadership,

Research and Specialized Areas of Clinical Practice. The increasing need for skills and knowledge beyond basic nursing preparation requires formal programs, both academic and clinical, supplemented by multiple opportunities for continuing education.

7. The Development of Nursing Standards and the Systematic Evaluation of Quality of Health Services Rendered. The professional association must provide measures to judge the competency of its membership and to evaluate the quality of their services.

8. The Accountability of Nursing. Nursing will be increasingly accountable to the public it serves. Social change will demand greater participation by nurses in social planning as it affects health and as an adovcate for the patient/client.

9. The Legislative Base for Nursing Practice. Changing needs will require that new roles develop; new roles will require appropriate changes in practice laws.

10. Patient Consumer Rights. Nurses must respect and support consumer rights in health care: to be informed; to be respected as an individual with major responsibility for his own health care; right to participate in decision-making affecting his health; and right to equal access to health care regardless of the individual's economic status, sex, age, creed, ethnic origin and location.

11. Economics of Health Care. Nurses must be informed about the cost efficiency of the health care system, the accessibility of service and effectiveness of results.

The above eleven factors should be kept in mind when evaluating the current and future practice and education of nurses. For example, how will these be reflected in the proposed system of nursing education for Alberta?

In connection with the above, the Task Force noted that over a decade ago Rogers (1964) wrote about "the evolving world of nursing". Her comments reflect the nature of the Task Force's view of the direction nursing should take in Alberta.

She states:

> The complexity of knowledge and skill required to safeguard the recipients of nursing service has made mandatory the identification of a nucleus of professionally educated nurses distinct from those whose preparation is technical or vocational in nature. (Rogers 1964:3)

> Indispensable to the development of professional education in nursing is a philosophy of nursing as a learned profession. (Rogers 1964:10)

Recognizing the above stated issues and trends, the Task Force believes nursing education should educate nurses who will transform scientific knowledge into humanistic care, and who will be able to practise in a society which will increasingly demand high quality health care delivered by competent professional persons. This position is further developed by Christman (1972). He states:

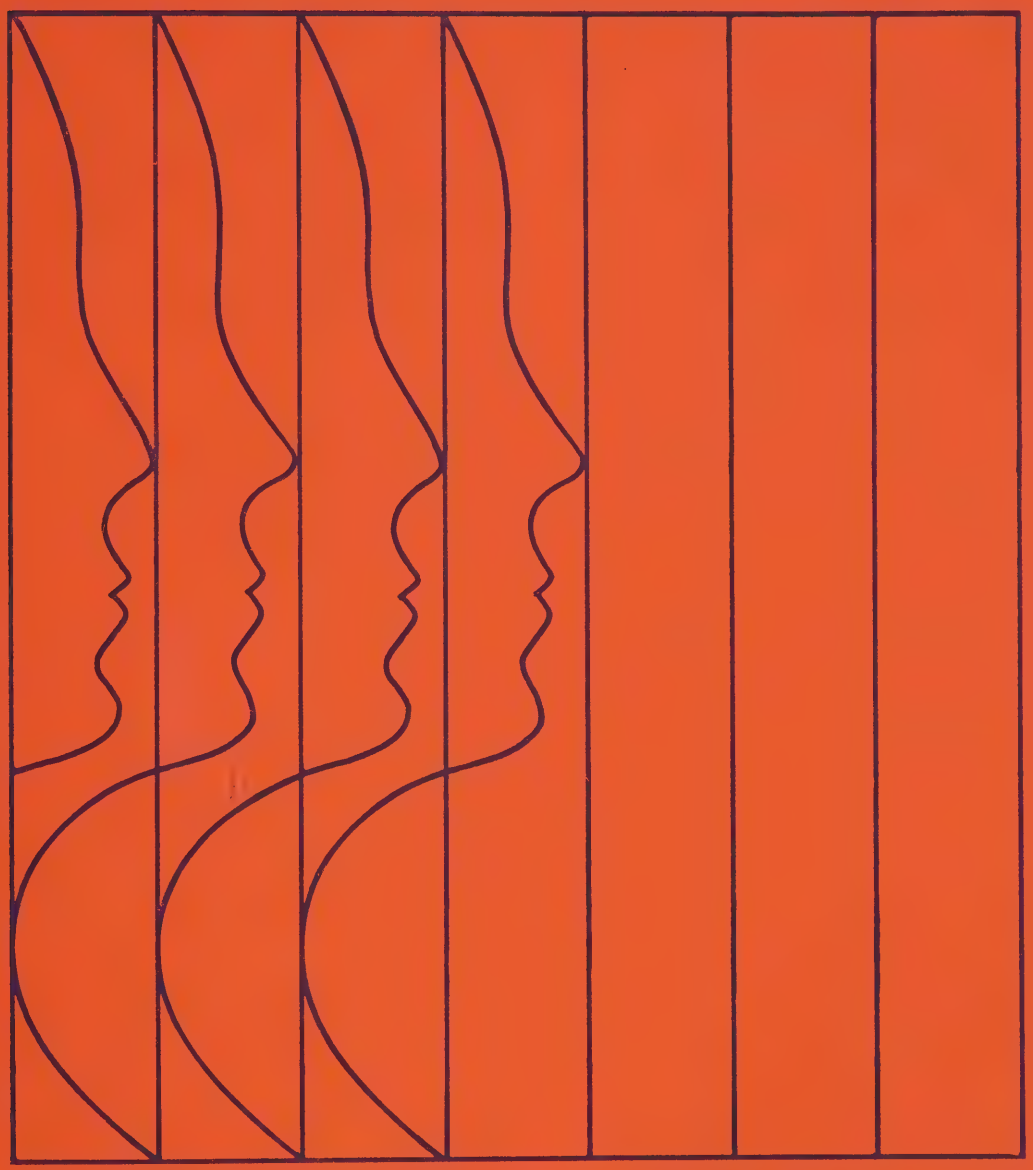
> Everything that nurses do in clinical practice comes out of some element of basic science, either behavioral or biophysical or both. The curriculum should be the mechanism by which this process gets conceptualized. It is an attitudinal orientation as well as a behavioral process. How do we bring about this desired end? How do we develop the orientation,

the clinical practice style, and the inquiring mind for the rest of each practitioner's life?

A few basic premises must be adopted to guide the construction of a curriculum that is designed to answer, at least in part, this set of questions. First, nursing must be perceived as an applied science. Second, the student must be educated as a generalist. Third, sciences cannot be conceived of as being static. They are a surging kind of phenomena. There always is new knowledge being poured into the system. To tie the three premises together a knowledge-linkage system must be the modus operandi of the curriculum design.

The above discussion of the role and functions of nursing indicates that nursing personnel must be oriented to a broad perspective if they are to contribute creatively to the health-care needs of society. The educational preparation required to develop such a perspective is discussed in detail in subsequent chapters.

Chapter 4



CATEGORIES OF NURSING PERSONNEL AND THEIR EDUCATIONAL PREPARATION

CATEGORIES OF NURSING PERSONNEL AND THEIR EDUCATIONAL PREPARATION

Previous chapters have reported the Task Force's examination of the health-service needs of Albertans, and the contribution nursing makes, and could make, in meeting them. In view of these examinations, and in the light of submissions presented by various groups concerned with the provision of health services, the Task Force delineated the following four assumptions regarding the nature of nursing personnel needed in the province:

1. There is a need for helpers who will complement and substitute for family and relatives in caring for the personal needs of patients. These are people who have strong desires to give this kind of assistance, but who do not wish, or are unable, to obtain adequate, formal nursing education. This group is later referred to as *personal care aides.*

2. There is also a need for people, trained in providing assigned nursing care, who function in controlled situations, but who do not wish, or are unable, to assume responsibility for overall planning and management of nursing care. This is the *Nursing Assistant* group.

3. In addition, there is a need for people, trained in nursing care as a career, who can progress to increasing professional responsibilities in the planning, provision and management of nursing care from the simplest to very complex situations. This is the group which leads from the *current diploma* in nursing to the *baccalaureate* in nursing.

4. Finally, there is a need for nurses who will reach greater degrees of specialization in the provision of services, through the development and application of nursing knowledge in:

   (a) the administration of nursing-care delivery systems within hospitals and community-care settings;
   (b) the education of health personnel and consumers;
   (c) the management of people along the health/illness continuum;
   (d) research in nursing practice.

This sophistication and/or specialization, which should be applicable to both healthy and diseased states, represents nurse preparation at the *Master's* and *Doctoral* levels.

Guided by these assumptions and the information that led to their formulation, the Task Force enunciated what it considers to be the actual levels of nursing practice required in Alberta. Subsequently, it formulated the general nature of educational programs necessary to prepare for these levels of practice or service.

PERSONAL CARE AIDE

Defined in the Task Force's first assumption as "helpers who will complement and substitute for family and relatives in caring for the personal needs of patients", personal care aides assist clients in activities of daily living, such as bathing, personal grooming, dressing and undressing, eating, elimination, ambulation, exercise, and diversional and recreational activities.

The Task Force delegates primary responsibility for the management and coordination of patient care to the registered

nurse, and in no way condones the use of aides in a para-professional or professional nursing capacity.

Task Force members do recognize, however, that service institutions have a legitimate and ongoing need for a level of worker in the personal-care-aide category. Training a special category of worker within the formal education system is not considered practicable or desirable in meeting this level of need. Instead, tailor-made, on-the-job training, delivered in a structured educational format, is seen as a far better approach.

All necessary training should be structured, planned and carried out by fully qualified individuals, and provided by the service agencies themselves, through contractual arrangements with an educational institution, or by some combination of the two approaches.

The Task Force suggests the following criteria as a guide for training personal care aides:

1. An accurate job description be prepared according to the specific-care-aide needs of the institution involved;

2. Training be limited to the areas of personal care;

3. Training programs be structured and be directed and conducted by a resource person (resident or visiting), and include supervised practicum experience;

4. No formal certificate or diploma be issued.

NURSING ASSISTANT

Although nurses never relinquish their responsibility for providing nursing service in home, hospital or community, they may delegate certain activities to nursing assistants, who can undertake certain activities which do not require the degree of knowledge and judgement demanded of the professional nurse. As pointed out in Nursing Aide Program/73. (Alberta: Department of Health and Social Development, 1973:2-3) this assistant group is intended to care for patients with convalescent conditions, and/or persons with sub-acute or long-term, stabilized medical problems. They provide nursing care under the supervision of a registered nurse "to patients in simple nursing situations", defined as ones that are "relatively free of scientific problems and can be performed by following a defined procedure step-by-step". Nursing assistants may be expected "to have a thorough knowledge of simple nursing procedures" so they "carry out basic nursing measures efficiently under the direction of a professional nurse". In more complex situations, they function as assistants to registered nurses.

While the above implies only an elementary understanding of the science underlying the activities performed, considerable dexterity and accuracy in performing specific nursing activities is required. Also implied is an appreciation of the importance of careful observation and accurate reporting to the registered nurse, together with skill in developing pleasant, helpful relationships with others, and a willingness to accept guidance and supervision.

The Task Force envisions a basic level of nursing-assistant training and practice which combines the current nursing-aide and nursing-orderly preparation in Alberta. It also sees the possibility of making available to nursing assistants some additional skills within specific clinical areas.

LEVELS OF PROFESSIONAL NURSING PRACTICE

According to the division of responsibilities as assigned by health-service agencies, nursing practice can be viewed from five levels:

1. Staff nurse (beginning or experienced);

2. Nursing team leader;

3. Head nurse and assistant head nurse;

4. Nursing specialists: supervisor, coordinator, clinical specialist, teacher-practitioner, nurse-researcher, family nurse practitioner;

5. Nursing administrator and nursing consultant.

Implied in each level of responsibility is a corresponding level of complexity in performance, requiring various degrees of knowledge and skill (cognitive, interpersonal and psychomotor). There may also be different personal attributes involved.

For purposes of this discussion the Task Force decided to begin with the level involving the largest group in nursing practice - the "staff" nurse in the institutional health agency. Thereafter, consideration is given to the "staff" nurse in community health service, followed by nursing positions of greater or differential responsibility (including head nurse, supervisor, clinical specialist, family nurse practitioner, practitioner-teacher, nurse-researcher, nursing administrator and consultant).

In the case of the staff nurse, the ideas expressed relate to the beginning nurse, that is, the nurse filling a staff position for the first time following graduation.

THE BEGINNING STAFF NURSE: INSTITUTIONAL HEALTH AGENCY

At present in Alberta, the majority of staff nurses beginning work in health-service institutions are "diploma" nursing graduates, who are also registered nurses, having passed the qualifying examinations. In its deliberations on the level of performance of the staff nurse, the Task Force was assisted by submissions from a representative group of directors of nursing and in-service coordinators in Alberta, and from the directors of diploma schools of nursing in the province. The two submissions contained many similarities. The Task Force also received materials from the Alberta Association of Registered Nurses.

Skills Required of the Beginning Staff Nurse: Institutional Health Agency

With respect to skills required of the beginning staff nurse in the institutional health agency, the Task Force considered them within the following classifications: cognitive (intellectual), affective (inter-personal), and psychomotor

(procedural). Although the beginning staff nurse integrates all these skills within nursing practice, for the sake of clarity they are considered here separately.

COGNITIVE SKILLS. Chief among the required cognitive or intellectual skills are those implied in the current use of the term "the nursing process", which is conceptualized as an orderly, systematic manner of determining a client's strengths and weaknesses, making plans to solve them, initiating and carrying out the nursing actions and evaluating the extent to which problems were resolved. This process should include the input of the client and/or family.

Further analysis of the nursing process results in a breakdown of its four components: assessment, planning, implementation and evaluation.

Assessment can be defined as a systematic, critical and precise method of collecting, validating, interpreting, analyzing, and synthesizing information about a client's physical, psychological and social needs, thus arriving at a nursing diagnosis.

The second component, planning, means determining what can be done to assist the client, by defining and stating expected outcomes in terms of the client's behaviour which can be observed and measured. This implies a deadline and reflects, "How can nursing make a difference?"

Implementation, the third component, is the initiation and continuance of nursing actions, be they communicative or technical, to meet the expected outcome. This implies continued monitoring of the client's status.

Finally, evaluation is testing the outcome of the nursing actions against previously pre-determined expected outcomes; expressing a value judgement and measurement against a standard which, in turn, provides the nurse with new data upon which to make revisions and/or decisions; and self-evaluation of one's own effectiveness. As will be obvious, the "nursing process" is a continous one and its effectiveness depends on a feedback mechanism, and an accurate knowledge and current application of the biological, behavioural, bio-social and medical sciences. In addition, high degrees of accuracy in observation, perception and interpretation are needed.

AFFECTIVE SKILLS. Working with people (patients and their families, other nursing personnel, and a host of other health workers) demands considerable skills in interpersonal relations, including those relating to accurate and effective communication, and in establishing positive and beneficial relationships with others (conveying a feeling of genuine caring and compassion, as well as an honest sense of proficiency in practice). To effectively teach individuals about health care, the staff nurse requires background knowledge from the behavioural sciences.

PSYCHOMOTOR SKILLS. The beginning staff nurse should be fairly proficient in the *common* technical aspects (procedures) of nursing practice, and have some added expertise related to a particular area of nursing practice. The remaining specialized or unusual technical procedures are generally learned through experience, in-service educational opportunities and/or further education. Nurses, employers,

professional associations and educational institutions must all contribute to the development of this increased expertise.

LEADERSHIP AND MANAGEMENT SKILLS. In addition to the above intellectual, interpersonal and procedural competencies, the beginning staff nurse needs some skill in leadership and management as these relate to the provision of nursing service to groups of patients. Two current practice modes include team nursing and primary nursing.

Primary nursing is a concept which includes:

> Assignment of each patient to a nurse who assumes primary responsibility for assessing and planning care throughout the patient's hospitalization and who provides direct care to the patient/family when she is on duty.
>
> Acceptance by the primary nurse of 24-hour responsibility for nursing care, planning, and evaluation of the care of patients in her caseload through written directives and verbal communications, within and across disciplines.
>
> Ordering of information processes, including discharge planning, as a possible solution to the discontinuities, fragmentation and associated dissatisfactions in and of the nursing care subsystem. (Bailey, 1975:57)

Team nursing is another organizational model for patient care management. In the opinion of the Task Force, the nursing pre-service program should include introduction to leadership and management with both theoretical and practical opportunities, so that with experience, and in-service the staff nurse is able to assume leadership of a nursing team in a patient-care unit. Further experience (directors of nursing and in-service coordinators suggest one to three months) should permit the staff nurse to assume "nurse-in-charge" duties for a patient-care unit while on various tours of duty. Leadership and management beyond this level require additional experience and education.

NURSING PRACTICE OBJECTIVES. Submissions to the Task Force from nursing-service and nursing-education personnel revealed a consensus on the nature of the patient-care functions involved in nursing practice. Nursing service personnel chose Abdellah *et al.* (1960) as their source for these functions. Considered pertinent to all patients experiencing common health problems (regardless of their customary classification into medical, surgical, paediatric, obstetric, psychiatric and the like) these objectives, termed "nursing problems" by Abdellah *et al.* (1960:16-17), include:

1. To maintain good hygiene and physical comfort.
2. To promote optimal activity; exercise, rest and sleep.
3. To promote safety through the prevention of accident, injury or other trauma and through the prevention of the spread of infection.
4. To maintain good body mechanics and prevent and correct deformities.
5. To facilitate the maintenance of a supply of oxygen to all body cells.
6. To facilitate the maintenance of nutrition of all body cells.
7. To facilitate the maintenance of elimination.
8. To facilitate the maintenance of fluid and electrolyte balance.
9. To recognize the physiological responses of the body to disease conditions — pathological, physiological, and compensatory.

10. To facilitate the maintenance of regulatory mechanisms and functions.
11. To facilitate the maintenance of sensory function.
12. To identify and accept positive and negative expression, feelings, and reactions.
13. To identify and accept the interrelatedness of emotions and organic illness.
14. To facilitate the maintenance of effective verbal and non-verbal communication.
15. To promote the development of productive interpersonal relationships.
16. To facilitate progress toward achievement of personal spiritual goals.
17. To create and/or maintain a therapeutic environment.
18. To facilitate awareness of self as an individual with varying physical, emotional, and developmental needs.
19. To accept the optimum possible goals in the light of limitations, physical and emotional.
20. To use community resources as an aid in resolving problems arising from illness.
21. To understand the role of social problems as influencing factors in the cause of illness.

A list of nursing skills which Abdellah *et al.* (1960:17-19) views as necessary to the meeting of these objectives follows:

1. Observation of health status
    - of well person
    - of patient with physical health problem
    - of patient with emotional health problem

2. Skills of communication
    - verbal
    - nonverbal
    - written

3. Application of knowledge
    - physical sciences
    - biological sciences
    - social sciences
    - nursing sciences
    - other general education

4. Teaching of patients and families
    - spontaneous teaching
    - planned individual instruction
    - spontaneous group teaching
    - planned group teaching

5. Planning an organization of work
    - individual patient care
    - group care of patient
    - emergency or stress situation
    - as a nursing team member
    - as a health team member

6. Use of resource materials
    - hospital records
    - medical records
    - reference materials
    - library

7. Use of personnel resources
    - patient, family, and friends
    - medical staff
    - dietary staff
    - technical staff
    - social service staff
    - occupational therapy staff
    - physical therapy staff
    - hospital administrative staff
    - community agency staff
    - clergy
    - other professional nurses
    - nursing auxiliary

8. Problem-solving
    - implementing plan for care
    - evaluating care given

9. Direction of work of others
    - planning
    - assigning
    - teaching
    - supervising
    - evaluating

10. Therapeutic use of the self
    - identification of own feelings
    - identification of own needs
    - establishing own goals
        - personal
        - nursing care
        - professional
    - assessment of own growth toward goals
        - use of moral and ethical values consistent with professional nursing.

11. Nursing procedures
    - ingestion
    - instillation
    - injection
    - inhalation
    - removal
    - applications
    - diagnostic procedures
    - comfort and support
    - safety.

In the opinion of the Task Force, the skills and knowledge involved in providing safe, effective care as outlined above requires professional nursing preparation at the baccalaureate level. Further elaboration of this position and the mechanism to achieve it within a specified time frame is documented in Chapter 6.

The Task Force also supports the view of differentiating levels of professional practice in terms of competence shown in clinical practice, administration, education and research. The Task Force emphasizes the need for both accurate assessment of nurses in these areas, and for sliding salary scales to reflect differential nurse-level functioning.

The effectiveness of a total health-care system within an institution depends on the combined efforts of a variety of health workers. Most health workers support the concepts of coordination, constancy, continuity and advocacy of patient care, but there is little assurance clients do, in fact, experience such service. As defined here, coordination is the integration of all services appropriate to the individual's and group's health needs; constancy is provision of uninterrupted care in time of illness; continuity implies non-fragmented care over the entire health-illness continuum and throughout the life cycle; and advocacy means speaking for the health-care rights of consumers.

If institutional nurses assumed the responsibility for implementing these concepts, it is possible all involved would benefit, particularly the consumers.

THE BEGINNING STAFF NURSE: COMMUNITY HEALTH SERVICE

The nurse in the community-based agency (public health nurse), or in so-called expanded roles in physician's offices or health centres, functions in all areas of health service to individuals, families and communities.

Included in the community health nurse's cognitive and interpersonal skills are, of course, skills in observation, perception, interpretation, analysis, synthesis, decision-

making, communication, teaching and counselling. To a considerable extent, the nature of the psychomotor skills required will vary with the nature of the nursing practice. Proficiency in the common nursing skills required of the beginning nurse working in the institutional setting is also expected.

The nurse in the community assists individuals, families and communities with the maintenance and promotion of health in the physiological, psychological and social realms. She collects relevant health, illness and social data about individuals, families and communities to identify those at risk of illness or injury, and she oversees any necessary preventive action. She identifies and assesses physical and behavioural deviations from "normal" human functioning at all age levels, and ensures the provision of necessary assistance and/or intervention.

The community-based nurse provides guidance for and supervision of health practices regarding physiological, psychological and social functioning, thereby helping people to prevent illness and to understand and participate in any necessary treatment regimens. She sustains, supports and cares for people of all ages, during life crises and other periods of dependence resulting from such factors as genetic failures, illness, injury, infirmity and deprivation.

She helps in the initiation and ongoing supervision of rehabilitation and restoration measures for persons needing long-term therapeutic programs. She may supervise and manage the care of normal pregnant women, as well as those with common health deviations.

Her teaching and counselling cover many aspects of healthful living, including those related to parenthood and pregnancy, birth control, nutrition, alcoholism and drug abuse, communicable disease control, the promotion of mental health and growing old gracefully. She is familiar with the functions of other health and social service personnel, and the community at large, and works effectively with them. In remote isolated areas she often has to assume responsibility for activities usually performed by physicians and/or other professionals.

Three basic concepts can summarize the role and functions of the community health nurse (Tinkham and Voorhies, 1972:114):

> Community health nursing is the field of nursing in which the family and community are the patients. Although it is concerned with the total health-illness spectrum, its primary focus is on the prevention of disease, and the promotion and maintenance of the highest level of health and well-being.
>
> The community health nurse works collaboratively with families and groups in identifying their health problems and nursing needs, in determining the nursing care plan, in mobilizing appropriate community resources, and in evaluating the nursing services given. She may provide the care herself or coordinate the services rendered by other members of the nursing and health team.

> The community health nurse participates with professional and lay persons in identifying the factors within the community relevant to health. She collaborates in planning, implementing, and evaluating the community health program, and assumes leadership in interpreting nursing and defining nursing needs.

From this discussion, it is obvious the community health nurse requires extensive knowledge from the biological, behavioural, bio-social and medical sciences, at least to the level of a baccalaureate degree. Since much of the community health nurse's practice is independent in nature, the beginning nurse must be able to function in a self-directive manner and be cognizant of resources to tap for any needed assistance (for example, nursing consultants).

PROFESSIONAL CHARACTERISTICS OF THE BEGINNING STAFF NURSE

Concerning the professional characteristics of the beginning staff nurse, a representative group of directors of nursing and in-service coordinators in Alberta expect her to demonstrate "initiative, self-discipline, reliability, self-direction, flexibility, a commitment to the ideal that care of patients is carried on 24 hours a day, seven days a week, and a degree of maturity in supporting the philosophy, objectives and policies of the agency". In addition, the nursing administrators expect the beginning staff nurse (1) to assume responsibility for maintaining and enhancing her competence in nursing practice; (2) to be cognizant of the medico-legal aspects of nursing practice; and (3) to maintain the ethical standards enunciated by the International Council of Nurses.

Concerning the last point, it is important to note that, though nurses subscribe to standards which respect the life, dignity and rights of man, research has often pointed out that the quality of care provided is affected by the recipient's income, education, social status, age, sex, colour, creed, and nationality. Consumers repeatedly inform us that their values, customs and spiritual beliefs are not truly respected. Nurses must recognize how their own attitudes and prejudices may affect their performance. Moreover, nurses should be prepared to accept, without condoning, those behaviours, experiences, activities which are contrary to or different from their own ethical standards.

NURSING POSITIONS OF GREATER AND/OR DIFFERENTIAL RESPONSIBILITY

Next, the Task Force turned its attention to the third and final level of nursing practice, the positions with greater and/or specialized responsibilities. In the case of head nurses and assistant head nurses, the knowledge and expertise of an experienced baccalaureate nursing graduate was considered desirable. These positions require a broad base of knowledge, educational preparation and practice, on which to base decisions and actions. Their competence is related to particular areas of clinical nursing practice, as well as to leadership, management, teaching, counselling and research.

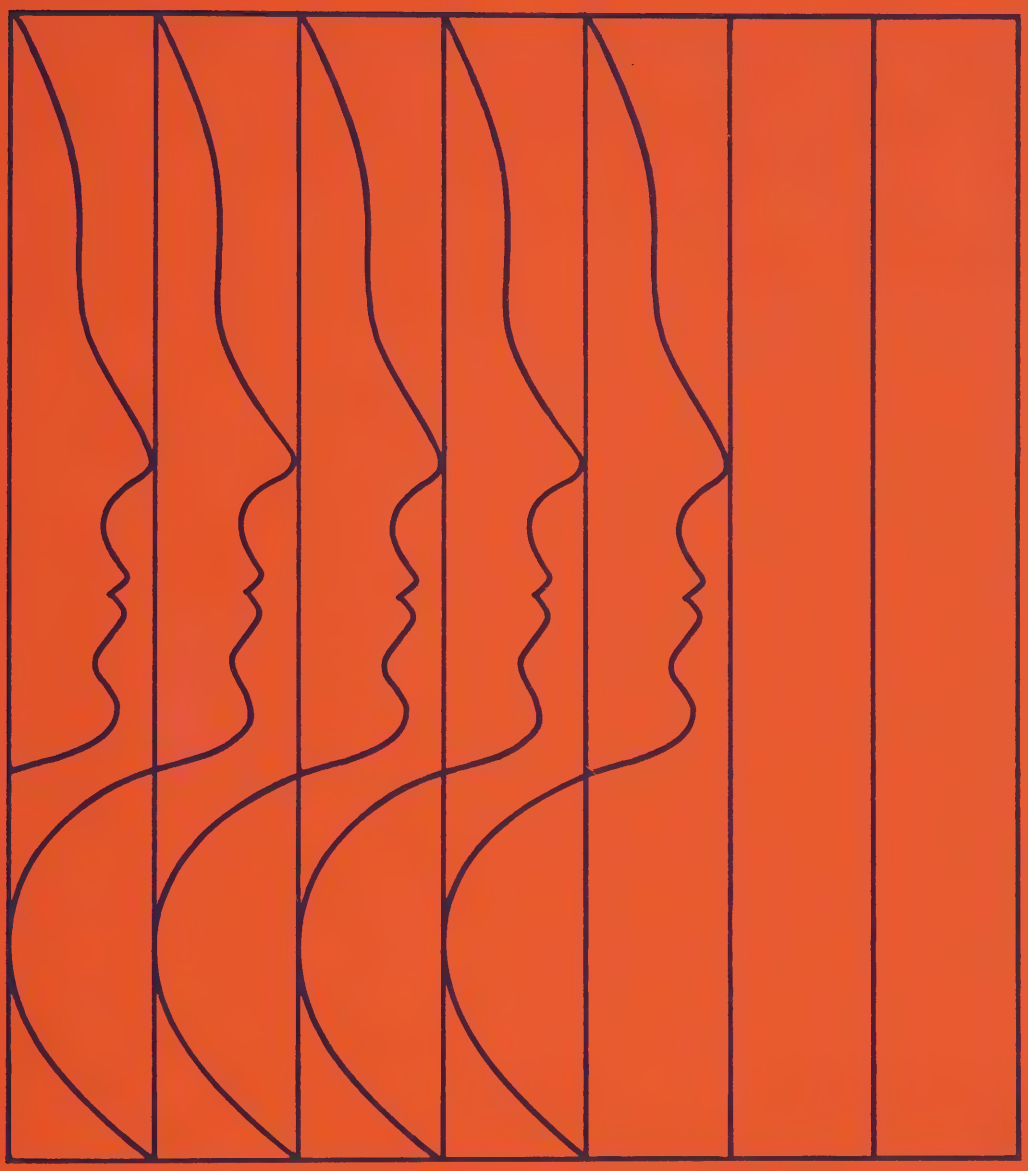
Talented baccalaureate graduates should be able to function as beginning family-nurse

practitioners (frequently referred to as nurse practitioners) and have an important role in primary health care. The *Report of the Committee on Nurse Practitioners,* (Boudreau, 1972) submitted to the Federal Department of Health and Welfare in April, 1972, recommended that "the development of the nurse practitioner category be regarded as the highest priority in meeting the primary health care needs in Canada" (p. 13). This committee's definition of primary health care and of the term "nurse practitioner", and the functions performed, as well as some of its recommendations, are presented in Appendix C:1.

Positions which require additional preparation beyond the baccalaureate at the Master's and Doctoral degree level would include the following: clinical nursing specialist, teacher-practitioner, nursing supervisor or coordinator, expert family-nurse practitioner, nursing administrator, nursing consultant, and nurse-researcher. In particular, it is considered important to emphasize that nursing administrators be prepared who can develop organizational structures and systems of patient-care delivery conducive to effective utilization of nursing personnel at the levels for which they are prepared.

In summary, the Task Force is of the opinion that the nursing profession must become more objective and scientific in assessing the effectiveness of its practice at all levels, and in undertaking the research necessary to determine the validity of the assumptions on which nurses base various aspects of their practice.

Chapter 5



THE CURRENT SITUATION OF NURSING EDUCATION IN ALBERTA

THE CURRENT SITUATION OF NURSING EDUCATION IN ALBERTA

The previous chapter made reference to the nature of nursing categories it sees as currently necessary in nursing practice, and the education required to prepare these categories. In order to ascertain the extent to which these mesh with current and future nursing programs, the Task Force surveyed the present situation with respect to categories of nursing, "manpower supply" and the existing education programs in Alberta.

In the process of examining the overall situation, several factors soon became apparent. There is no coordinated system for the preparation of nursing personnel in Alberta. A variety of institutions under various types of control are preparing different categories of workers. There seems to be an absence of any assessment of nursing "manpower" requirements, and little tangible evidence can be found of comprehensive planning to meet current or projected needs for nursing personnel. All of this has occurred despite the efforts, over the years, of the Alberta Association of Registered Nurses to draw attention to nursing education and service needs in the province.

QUALITY OF NURSING "MANPOWER" IN ALBERTA

While the categories of nursing personnel designated as essential in Chapter 4 are not unlike those currently in existence, notable dearths do exist with respect to a qualitative supply of these people.

In a brief to the Task Force, the Edmonton Regional Conference, Progressive Extended Care Division (1975) reported 80 to 90 percent of staff in facilities such as theirs are "untrained auxiliary nursing personnel". This surely is a situation leaving much to be desired. Persons resident in such institutions should have the quality of care provided by certified nursing aides and registered nursing orderlies, functioning under the direction of a well-prepared nurse or other specialist in long-term and/or geriatric care. Depending on the nature of the residents in auxiliary hospitals and nursing homes, it is possible that the personal care aides, referred to earlier in this report, may have a service contribution to make.

In the past, low salaries in auxiliary hospitals and nursing homes (in comparison with those in general hospitals) have reportedly deterred nursing aides and orderlies from choosing to work in these institutions. Now, however, the salary differential between the untrained staff and the nursing aides and orderlies is reported to be small. A concerted effort, therefore, is necessary to prepare and retain properly qualified personnel to work in extended-care agencies.

A review of appropriate literature and, if necessary, the undertaking of studies are advisable in determining the ratio of nursing assistants to registered nurses required to ensure maximum quality of patient-care at reasonable costs. This is needed for various kinds of nursing service units, since ratios will vary depending on the nature and acuity of patients' health problems. Similar studies on the appropriate "mix" of nursing personnel should include nurses prepared at the Master's level who are working as clinicians. Christman ("Profile", 1974) is among those who maintain that the most expensive nursing-staff member is not the clinical nursing specialist with the Master's degree, but rather

the nursing assistant. Part of the basis for this is the considerable amount of unoccupied time the assistant has in particular kinds of situations.

The Task Force has stated its endorsement of baccalaureate education for professional nursing practice and its support of a mandatory Master's degree, plus experience, for nursing teachers, clinical nursing specialists and nursing administrative positions. Nurses with Doctoral degrees are required for the continued development and application of nursing knowledge. The magnitude of the tasks the nursing education system must accomplish becomes apparent, when one compares the 1972 and 1973 data pertaining to the qualifications of persons holding various positions in nursing. Some of these data are reported in Table 3.

At the rate of progress made in 1972-73, it would take 21 years to upgrade the present supply of community nurses to the baccalaureate level; 56 years to bring the current number of assistant head nurses and head nurses to this level; and 265 years to bring the present number of teachers of nursing to the level of a Master's degree.

It is disconcerting to note that in 1973 less than two percent of directors of nursing or assistant directors of nursing in hospitals and other institutions, had qualifications at the Master's level or higher; only 12 percent had a baccalaureate degree, while more than three-quarters had no more than a diploma in nursing. The situation for nursing supervisors and assistant supervisors is equally discouraging. About six percent of head nurses and assistant head nurses, and slightly more than four percent of staff nurses, have achieved a baccalaureate degree.

In community nursing services (which include nurses in public health, ambulatory health centres, school health and occupational health), less than half of the directors and assistant directors and less than 29 percent of supervisors and assistant supervisors, had attained a baccalaureate level of preparation. This falls far short of the Task Force's view that the knowledge and skills of baccalaureate preparation are basic to the functioning of a staff nurse beginning in community nursing. In 1973, almost 46 percent of Alberta's community-service nurses had no preparation beyond a nursing diploma.

Present trends show a development of community-based health services offered on a continuous basis and oriented to health maintenance, promotion and disease prevention (distributive care). With the current diploma learning experiences based mainly in hospitals, which focus on curative and restorative aspects related to acute and chronic illness (episodic care), it is rather disconcerting to realize Alberta may be developing a service without adequately preparing personnel. The development of community-based programs may alleviate the demand on acute-care facilities, but, at the same time, create a need for a greater number of personnel in the distributive-care sector. The possibility of a shortage or lack of prepared personnel for the developing community-health services can only be altered if nursing education addresses itself to actual needs of people and the setting where most of these occur. Nursing education also needs to be developed within the context of political realities, that is, cost, and commitment to existing structures and facilities.

Table 3

NUMBER AND PERCENT OF SELECTED POSITIONS IN NURSING IN ALBERTA BY HIGHEST LEVEL OF EDUCATIONAL PREPARATION, 1973

Area of Nursing	Total No.	Change/ 1972*	Diploma No.	%	PC/ 1972**	Some credit toward Baccalaureate No.	%	PC/ 1972	Baccalaureate No.	%	PC/ 1972	Master's Degree and Higher No.	%	PC/ 1972
HOSPITALS OR OTHER INSTITUTIONS														
Director/Assistant Director	304	+ 13	231	75.99	– 1.33	30	9.87	– 0.78	37	12.17	+ 0.83	6	1.97	+ 1.28
Supervisor/Assistant Supervisor	354	– 5	273	77.12	– 2.55	49	13.84	– 0.09	30	8.47	+ 2.06	2	0.56	+ 0.56
Instructor	56	+ 2	23	41.07	+ 7.74	7	12.50	– 9.72	25	44.64	+ 0.20	1	1.79	+ 1.79
Head Nurse/Assistant Head Nurse	680	– 9	563	82.79	– 4.88	77	11.32	+ 3.19	40	5.88	+ 1.67	–	–	–
General Duty (staff nurse)	5937	–172	5210	87.75	– 1.10	483	8.14	+ 0.95	242	4.08	+ 0.17	2	0.03	– 0.02
COMMUNITY NURSING ***														
Director/Assistant Director	14	0	6	42.86	+ 14.29	2	14.29	– 7.14	6	42.86	– 7.14	–	–	–
Supervisor/Assistant Supervisor	113	+ 2	55	48.67	– 0.88	24	21.24	– 3.98	32	28.32	+ 4.00	2	1.77	+ 0.87
Instructor	3	– 2	2	66.67	–33.33	–	–	–	1	33.33	+ 33.33	–	–	–
Head Nurse/Assistant Head Nurse	10	+ 5	8	80.00	0	1	10.00	+10.00	1	10.00	–10.00	–	–	–
General Duty (staff nurse)	548	– 22	250	45.62	– 3.85	113	20.62	+ 0.80	184	33.58	+ 2.88	1	0.18	+ 0.18
SCHOOL OF NURSING														
Director/Assistant Director	19	– 4	–	–	–	–	–	–	8	42.11	+ 11.68	11	57.89	+ 1.37
Instructor/Professor	274	– 25	26	9.49	– 0.21	29	10.58	– 1.13	187	68.25	+ 0.69	32	11.68	+ 0.64

* Change/1972 = change from 1972. **PC/1972 = percentage change from 1972 ***includes Public Health, School Health and Occupational Health

SOURCE: Canadian Nurses Association. *COUNTDOWN* 1974. Ottawa, 1975:28; *COUNTDOWN* 1973. Ottawa, 1974:25.

With respect to the preparation of nursing educators, Table 3 again reveals the need for considerable upgrading. In 1973, only 58 percent of directors and assistant directors of nursing schools had a Master's degree or higher. Whereas a Master's level is considered minimum for most professional educators within institutions of higher learning, in nursing less than 12 precent hold this degree. Slightly more than two-thirds of nursing instructors had no more than a bachelor's degree, while just over 20 percent had less than this.

It becomes obvious Alberta has not achieved the educational standards considered necessary for effective nursing education and practice. A consideration of the current means by which the province's "nursing manpower" is prepared further clarifies this situation. This examination is presented below, with reference to the following factors: institutions preparing nursing personnel; admission standards and nature of programs offered; intake of students and output of graduates; and the retention of graduates in the labour force.

INSTITUTIONS PREPARING NURSING PERSONNEL

A summary of the type, location and control of institutions, which prepare nursing personnel in Alberta, is presented in Table 4.

A study of the data reveals several obvious issues. No specific agencies are responsible for the preparation of the non-professional categories such as health aides, nursing home aides, hospital assistants, and the like. The Nursing Aide Schools (located in Edmonton and Calgary) come under the jurisdiction of Social Services and Community Health, while nursing orderlies are prepared by the Alberta Vocational Centres (also in Edmonton and Calgary), institutions of Advanced Education and Manpower.

The Alberta Hospitals at Oliver and Ponoka are responsible for the preparation of psychiatric nurses, with supplementary programs in general nursing for Registered Psychiatric Nurses offered by Grant MacEwan and Red Deer Colleges. These supplementary programs qualify registered psychiatric nurses to write the Registered Nurse examinations.

Nursing divisions in five community colleges and in six hospital schools prepare nurses at the diploma level, and two universities offer four-year baccalaureate programs in nursing, all for high school graduates. The University of Alberta has a post-basic baccalaureate program for registered nurses, and is about to offer its first clinical Master's program called Nursing in Acute Illness.

Certificate Programs for registered nurses include the following: Occupational Health through Grant MacEwan; Nursing Management of Patient Care through Red Deer; and Advanced Practical Obstetrics and Northern Nurse Practitioner through the University of Alberta. Although baccalaureate nursing graduates can complete a Master's in Health Services Administration, this particular program is not considered a Master's degree in nursing. There are no programs in the province for the preparation of nursing teachers.

Table 4 points out the fact that no overall body monitors the standards of

Table 4

INSTITUTIONS PREPARING NURSING PERSONNEL, ALBERTA, 1975

Category of Nursing Personnel	Institutional Offering Program	Location of Institution	Frequency of Class Intake	Body Monitoring Program Standards	Body Qualifying Graduates
Health Aide, Nursing Home Aide, Hospital Assistant (and various other titles)*	Has included Alberta Vocational Center Local School Board.	Edmonton Calgary	As occasionally arranged.	Those offering program.	No official qualification.
	Employing agencies - nursing homes and/or auxiliary hospitals.	Various locations in province.	As necessary.	Those offering program.	No official qualification.
	Employing agencies with assistance from manpower department.	Calgary	As occasionally arranged.	Those offering program.	No official qualification.
Nursing Aide (Female)	Alberta Department of Social Services and Community Health.	Edmonton Calgary	6 times per year. (every 10 weeks)	NursingAide Advisory Council set up under the Nursing Aides Act.	Certification & registration by Director of Nursing Aide Education & Registrar-Consultant.
Nursing Orderly (Male)	Alberta Vocational Center.	Edmonton Calgary	3 times a year (every 20 weeks)	Those offering program.	No formal approval – "registration" with Alberta Associaiton of Nursing Orderlies.

Table 4 (continued)

INSTITUTIONS PREPARING NURSING PERSONNEL, ALBERTA, 1975

Category of Nursing Personnel	Institution offering Program	Location of Institution	Frequency of Class Intake	Body Monitoring Program Standards	Body Qualifying Graduates
Psychiatric Nurse	Alberta Hospital Alberta Hospital	Ponoka Edmonton	Once a year Once a year	Advisory Committee set up under the Psychiatric Nursing Training Act.	Certificate issued by the Advisory Committee. Registration by Psychiatric Nurses Association of Alberta.
Programs for Registered Psychiatric Nurses: Supplementary Nursing Program for Psychiatric Nurses to obtain a Registered Nursing Diploma.	Grant MacEwan College	Edmonton	Once a year	Nursing Education Committee of Universities Co-ordinating Council	Registration examinations – Canadian Nurses Association testing service. Registration by Alberta Association of Registered Nurses.
Supplementary Program in General Nursing for Registered Psychiatric Nurses.	Red Deer College	Red Deer	Once a year	Ditto	Ditto

Table 4 (continued)

INSTITUTIONS PREPARING NURSING PERSONNEL, ALBERTA, 1975

Category of Nursing Personnel	Institution Offering Program	Location of Institution	Frequency of Class Intake	Body Monitoring Program Standards	Body Qualifying Graduates
Diploma Nurse	Hospitals:				
	Misercordia	Edmonton	Once a year.	Nursing Education Committee of Universities Co-ordinating Council (same for all programs).	Registration Examinations – Canadian Nurses Association testing service. Registration by Alberta Association of Registered Nurses.
	Royal Alexandra	Edmonton	Once a year.		
	University of Alberta (Metro-Calgary & Rural	Edmonton	Every 4 months.		
	General Hospital District No. 93 Holy Cross School of Nursing	Calgary	Once a year.		
	Foothills	Calgary	Once a year.		
	(Lethbridge Municipal Hospital) Galt School of Nursing	Lethbridge	Once a year.		
	Community Colleges:				
	Grant MacEwan	Edmonton	Once a year.	Nursing Education Committee of Universities Co-ordinating Council (same for all programs).	Registration examinations – Canadian Nurses Association testing service. Registration by Alberta Association of Registered Nurses.
	Mount Royal	Calgary	Once a year.		
	Red Deer	Red Deer	Once a year.		
	Lethbridge	Lethbridge	Twice a year.		
	Medicine Hat	Medicine Hat	Once a year.		

Table 4 (continued)

INSTITUTIONS PREPARING NURSING PERSONNEL, ALBERTA, 1975

Category of Nursing Personnel	Institution Offering Program	Location of Institution	Frequency of Class Intake	Body Monitoring Program Standards	Body Qualifying Graduates
Programs for Registered Nurses:					
Occupational Health Nursing Certificate.	Grant MacEwan College	Edmonton	Once a year.	College.	Certificate from college.
Nursing Management of Patient Care.	Red Deer College	Red Deer	Dependent on demand. For part time students one course offered each term.	College.	
Certificate in Advanced Practical Obstetrics.	University of Alberta	Edmonton	Once a year.	University.	Certificate from university.
Northern Nurse Practitioner.	University of Alberta	Edmonton	Twice a year.	University.	Certificate from university.

Table 4 (continued)

INSTITUTIONS PREPARING NURSING PERSONNEL, ALBERTA, 1975

Category of Nursing Personnel	Institution Offering Program	Location of Institution	Frequency of Class Intake	Body Monitoring Program Standards	Body Qualifying Graduates
Baccalaureate Degree in Nursing:					
Program for high school graduates.	University of Alberta. University of Calgary.	Edmonton Calgary	Once a year. Once a year.	Nursing Education Committee of Universities Co-ordinating Council	University degree – Registration Examinations – Canadian Nurses Association testing service. Registration by Alberta Association of Registered Nurses.
Program for Registered Nurses.	University of Alberta. University of Alberta. (with assistance of University of Calgary).	Edmonton Calgary	Once a year. Once a year.	University.	University degree.
Master's Degree in Nursing:					
Nursing in Acute Illness.	University of Alberta	Edmonton	Initial class September 1975.	University.	University.
Health Services Administration.** (nursing administration).	University of Alberta	Edmonton	Once a year.	University.	University.

* Data in this section not necessarily complete.

** Not considered a Master's Degree in Nursing.

nursing educational programs in the province. Different groups assume responsibility for the various programs and their entrance requirements.

ADMISSION STANDARDS AND NATURE OF PROGRAMS OFFERED

In its study of the nature of nursing programs, the Task Force made no attempt to summarize the programs offered to the "health-aide" groups. In general, admission requirements are low and there are great variations in the kinds of programs offered. Some involve no more than a few days of working in a "buddy system" with an experienced worker.

Table 5 reports the admission standards, length of programs, and components of theory and practice for nursing aides, nursing orderlies, psychiatric nurses, diploma nurses and baccalaureate nurses. (For further details see Appendices D:1 through D:5).

Two of the differences in the nursing aide and nursing orderly programs, not apparent in Appendices D:1 and D:2, are:

1. Aide programs have 20 weeks of concentrated theory followed by 20 weeks of concentrated practice. Teachers during the concentrated practice period are not regular nursing-aide instructors, but rather individuals in agencies where the aide-trainees are gaining their "practical" experience. Orderly programs, on the other hand, combine theory and practice throughout the program, and clinical teachers are personnel employed by the Vocational Centre.

2. Aide-trainees receive no stipend and must assume financial responsibility for tuition, books and uniforms, while orderly trainees receive total financial support.

A point of interest is the similarity between the required hours set by the Co-ordinating Council of The Universities of Alberta (1970), for the diploma nurse program (1,500 hours), and those for the nursing aide (1,400 hours) and orderly (1,375 hours) programs. Furthermore, these hours of instruction and practice in the aide and orderly programs are offered in a 40-week period, whereas the minimum length of the diploma program for nurses is approximately 95 weeks (or exactly 22 months, exclusive of vacation).

As for the psychiatric nurse training programs offered at Alberta Hospital Edmonton and Alberta Hospital Ponoka, there is little difference between them in admission standards or the length of the entire program. There are, however, discrepancies in the amount of time spent in theory, laboratory practice and clinical practice. It is also noteworthy that, though this category of worker spends almost the same amount of time in training as the diploma registered nurse, she does not have the prerequisites to qualify as a registered nurse, and her career opportunities are thereby restricted.

Attention is also drawn to the range of weeks in the diploma programs offered by the different institutions and in the university nursing programs. The range is from 72 to 78 weeks in the college diploma programs, from 112 to 140 weeks in the hospital diploma programs, and from 116 to 123 weeks in the baccalaureate programs for high school

Table 5

ADMISSION STANDARDS, LENGTH OF PROGRAM AND HOURS OF THEORY AND PRACTICE, VARIOUS NURSING PROGRAMS, ALBERTA, 1975

Program	Admission Standards	Length of Program	Hours of Theory	Hours of Laboratory Practice	Clinical Practice
NURSING AIDE	Grade X Alberta with at least Mathematics, Science (preferably Biology) English and Social Studies. Age: 17.5 to 55 years.	40 weeks (1400 hours)	20 weeks (600 hours)	Included in theory figures	20 weeks (800 hours)
NURSING ORDERLY	Grade X Alberta or equivalent. Age: 18 to 55 years.	40 weeks (1375 hours)	479 hours	210 hours	686 hours
PSYCHIATRIC NURSE	Alberta Hospital Edmonton: Alberta High School Diploma with 100 credits, 50% or higher in English 30, one Grade XII Science, and two other Grade XII matriculation subjects.	24 months (92 weeks)	990 hours	107 hours	2048 hours
	Alberta Hospital Ponoka: Alberta High School Diploma with 100 credits, plus four Grade XII subjects preferably from the following: (1) English 30 or 33 (2) Social Studies 30 (3) Math 30 or 31 (4) 1 Grade XII Science preferably Biology (5) 1 Grade XII optional subject Age: 18 or over	24 months (92 weeks)	1100 hours	166 hours	1812 hours

Table 5 (continued)

ADMISSION STANDARDS, LENGTH OF PROGRAM AND HOURS OF THEORY AND PRACTICE, VARIOUS NURSING PROGRAMS, ALBERTA, 1975

Program	Admission Standards	Length of Program	Hours of Theory	Hours of Laboratory Practice	Clinical Practice
DIPLOMA NURSE	Regulations: (Coordinating Council of the Universities of Alberta). Alberta high school diploma with 100 credits, B or higher standing in one Grade XII English, one Grade XII Science and two other Grade XII subjects. Adult admission privilege in effect for those over 25 years. Range of admission requirements in 12 diploma programs vary from minimum requirement to particular standards in Senior Matriculation.	Regulations: minimum 22 months exclusive of vacation (converted to 96 weeks). 1500 hours "minimum of hours of classroom and planned supervised observation and practice of nursing." Range in college programs 72-78 weeks (1179-1807 hours). Range in hospital programs 112-140 weeks (3261-4246 hours).	Regulations: "not less than 800 hours theory and planned supervised observation and practice of nursing." Range in college programs 330-393 hours. 350+ hours (one school) Range in hospital programs 488-1141 hours.	Range in college programs – included in theory. 120+ hours (one school) Range in hospital programs 44-627 hours.	Regulations: "300 hours of planned, supervised clinical practice in the patient care areas." Range in college programs 786-1430 hours. 950+ hours (one school) Range in hospital programs 2377-3261 hours.

Table 5 (continued)

ADMISSION STANDARDS, LENGTH OF PROGRAM AND HOURS OF THEORY AND PRACTICE, VARIOUS NURSING PROGRAMS, ALBERTA, 1975

Program	Admission Standards	Length of Program	Hours of Theory	Hours of Laboratory Practice	Clinical Practice
BACCALAUREATE NURSE	University of Calgary: Grade XII senior matriculation overall average at least 65.0 with 50 or equivalent in English 30, Mathematics 30, Biology 30, Chemistry 30, plus one other specified five credit Grade XII subject.	123 weeks (1757 hours).	429 hours		1328 hours
	University of Alberta: High school graduation diploma with a "B" or higher standing in grade XII. English 30, Chemistry 30, Biology 30 and two remaining subjects from Group A (Humanities) or B (Sciences). Overall average of at least 65 percent in 5 courses.	116 weeks (2498 hours).	666 hours		1832 hours

graduates. Given the Universities Co-ordinating Council's 1,500 hours minimum "classroom and planned supervised observation and practice of nursing", there seems to be no justification for the ranges of hours found in diploma nursing programs: 1,179 to 1,807 in college-based programs and 3,261 to 4,246 in hospital-based programs.

Since these hours were submitted to the Task Force by individual schools, in response to the request for information on programs, the discrepancies may be the result of different interpretations as to what constitutes nursing theory. Even with this possibility, it seems reasonable to suggest a need for further consensus on the amount of time required for theory and practice at the diploma level.

A greater delineation of expected outcomes from the various preparatory programs might shed some light on the relationship of time, educational process and eventual performance. It is well documented by educational research that time is not equatable with performance, that is, different tasks (cognitive, affective, psychomotor) are learned at different rates and by different means. Rather than arbitrarily-set hours dictating the duration of didactic and practicum instruction, clear expectations of different levels within the education programs and of terminal competencies of the graduates would help delineate educationally-sound time-frames and learning experiences.

INTAKE OF STUDENTS, OUTPUT OF GRADUATES

Concerning the issue of student intake and graduate output, little is known about programs offered to so-called "health aides". There are, however, some data on other categories.

Nursing Aides and Orderlies

Each of the nursing-aide programs, offered by Social Services and Community Health in Edmonton and Calgary, has a capacity of 120 students per class, with classes enrolled every 10 weeks (approximately six per year). Orderly programs are offered three times a year (every 20 weeks) at the Alberta Vocational Centres in Edmonton and Calgary. Each has a capacity of 35 students. The only figures available at this time indicate a class size in Edmonton of 24 in 1967 and 31 in 1974.[1]

In 1973, admissions to the 131 provincially-approved programs in Canada totalled 6,296. Of this number, five percent were men. The Canadian trends, regarding admissions to nursing-assistant programs, are reported by the Canadian Nurses Association as follows:

> Admissions to provincially-approved programs for nursing assistants rose each year between 1967 and 1969, from 5,089 to 5,478, for a total increase of 8%. In 1970, there was a decrease of 6% from the previous year, and in 1971 a decrease of 8% from 1970. However, in 1972 there was an increase of 11% over the previous year, and in 1973 there was an increase of 10% (Canadian Nurses Association, 1975:111).

Table 6 gives figures on nursing-aide admissions and graduations in Alberta, 1969-1973.

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[1] Alberta Vocational Centre, Edmonton. Faculty of Nursing Orderly Program. "The Preparation and Articulation of Health Care Workers Educated in Short Term Programs." A Position Paper to the Alberta Task Force on Nursing Education. Edmonton, 1975:9.

Table 6

ADMISSIONS AND GRADUATIONS, PROVINCIALLY-APPROVED PROGRAMS FOR NURSING ASSISTANTS, ALBERTA, 1969-1973

Year	Admissions No.	Graduations No.	Graduations as Percent of Admissions %
1969	571	491	85.99
1970	634	453	71.45
1971	637	487	76.45
1972	592	454	76.89
1973	549	408	74.32

SOURCE : Canadian Nurses Association, *Countdown* 1974. Ottawa, 1975: 114-115.

This table shows the output of nursing assistants in Alberta declining between 1969 and 1973, except for one year, 1971. The overall attrition rate since 1971 has been about 25 percent. (In the Edmonton-centered nursing orderly program between 1967 and 1970 this rate was 18.6 percent; however, during the period from 1972 to 1975 it rose significantly to 48.3 percent.[2])

Psychiatric Nurses

The psychiatric nursing programs at Edmonton and Ponoka admit classes once a year. By 1975, 313 psychiatric nurses were registered with their Association. Table 7 gives figures on psychiatric nurse admissions and graduates in Alberta, 1969-1973.

Table 7

ADMISSIONS AND GRADUATIONS, PROVINCIALLY-APPROVED PROGRAMS FOR PSYCHIATRIC NURSES, ALBERTA, 1969-1973

Year	Admissions No.	Graduations No.	Graduations as Percent of Admissions %
1969	–	34	
1970	67	44	65.67
1971	65	47	72.31
1972	64	47	73.44
1973	68	45	66.17

SOURCE: Alberta Hospitals at Ponoka and Edmonton – Schools of Nursing.

[2] *Loc. cit.*, p. 8

Diploma Nurses

As background for considering admissions to diploma-nursing programs in Alberta, data for Canada were examined. In 1973, there were 11,459 students admitted to 142 programs in Canada. Of these, 101 were in educational institutions within the general education system at the advanced education level. These 101 programs admitted 9,001 students, 79 percent of total admissions to diploma-nursing programs. Data on admissions and graduations from diploma-nursing programs in Alberta, 1969 to 1973, are presented in Table 8.

Table 8

ADMISSIONS AND GRADUATIONS, DIPLOMA NURSING PROGRAMS, ALBERTA, 1969-1973

Year	Admissions No.	Graduations No.	Graduations as Percent of Admissions %
1969	890	634	71.24
1970	834	732	87.77
1971	871	654	75.09
1972	792	683	86.24
1973	845	565	66.86

SOURCE: Canadian Nurses Association. *Countdown* 1974. Ottawa, 1975: 74, 83.

In 1973, only slightly more than two-thirds of the students, admitted to nursing-diploma programs, completed the course. Perhaps this was an unusual year; however, if this situation persisted in 1974 and again in 1975, the matter is cause for investigation.

Baccalaureate Programs for High School Graduates

Looking first at the Canadian scene, one finds from 1964 to 1972 graduations from baccalaureate programs in Canada increased by only four percent; that is, from two percent of all students entering initial nursing programs (diploma and baccalaureate combined) to six percent. This increase is reflected in the following changes in the ratio of baccalaureate to diploma nursing graduates: 1964, 1:46; 1972, 1:20; 1973, 1:15. Enrollment figures for Alberta baccalaureate programs are presented in Table 9.

Table 9

ENROLLMENT IN BASIC BACCALAUREATE NURSING PROGRAMS, ALBERTA, 1969-1973

University	Year				
	1969	1970	1971	1972	1973
University of Alberta	155	133	145	152	162
University of Calgary		52	75	123	176

SOURCE: Canadian Nurses Association. *Countdown* 1974. Ottawa, 1975:80.

In 1973, only 27 nurses graduated from basic baccalaureate programs in Alberta. It is to be noted the University of Calgary graduated its first class of 33 nurses in 1974. The 1973 ratio of baccalaureate to diploma nurses graduating in Alberta was 1:21. (The national average in that year was 1:15). With the University of Calgary's baccalaureate program, Alberta figures for 1974 and 1975 should be more in line with other Canadian regions.

Baccalaureate Programs for Registered Nurses

In 1973, the University of Alberta's Post-Basic degree program enrolled 217 registered nurses. Dr. S. Stinson, in a communication to the Task Force's chairman, stated the number of applicants for this program "*far* exceeds the current University of Alberta resources . . . and that we at the

University of Alberta *might* be able to expand our Post-Basic program *if* clinical facilities and full-time faculty allotments were expanded to permit same." A submission to the Task Force, from the University of Alberta nursing faculty responsible for the registered-nursing baccalaureate program, indicated the Post-Basic program "has been forced to establish enrollment quotas while faced with an upsurge in qualified applicants" (240 applicants for 72 spaces).

The number of registered nurses granted degrees by the University of Alberta in 1973 was 81. In an attempt to meet the demands of registered nurses for degree qualification, the University of Alberta nursing faculty, with assistance from the Faculty of Nursing at the University of Calgary, is now offering courses in Calgary. The University of Calgary has submitted a letter of intent to Advanced Education and Manpower regarding initiation of a degree program for registered nurses. The Task Force strongly endorses and supports this move.

NURSING PERSONNEL IN THE LABOUR FORCE

Turning to the subject of nursing personnel in the labour force, one issue that was brought to the attention of the Task Force on several occasions was that of a critical shortage of nursing personnel in the field of mental health. This problem is further complicated by a current lack of agreement as to what constitutes appropriate training in this field and by the current transition of service from a system based on centralized care in the province's two mental hospitals to one which emphasizes decentralization and the development of community-based care.

In view of the above complexities and the fact that this matter is currently under review by other agencies, the Task Force felt that it was unable to deal adequately with this subject, but strongly endorses the review and resolution of the issues by the appropriate provincial bodies.

The Task Force was also made aware of various proposals emanating from a number of sources to train nurses in the field of mental health. Insofar as those proposals are directed at alleviating the current manpower shortage in this area, it would seem appropriate that active consideration be given to their implementation on a short-term basis.

With respect to other categories of nursing personnel, the Task Force received more detailed information concerning such factors as retention, turn-over rates, vacancy figures, and characteristics of a female dominated labour force.

On the subject of retention, the Task Force learned that it was not unusual for nursing orderlies to move into other paramedical positions, such as ambulance attendants and operating-room technicians. Little is known about the retention of nursing aides, other than that some specialize in operating-room technician work and some enter registered-nurse programs.

The Canadian Nurses Association (1975:11) provides some data on the employment status of registered nurses in Alberta. In 1973 there were 11,644 registered nurses in Alberta. Of this number 8,797 (75.7 percent) were employed in nursing,

while 2,731 (23.5 percent) were no longer engaged in nursing practice. The employment status of the remaining 86 (0.8 percent) is not known. It is reasonable to assume many nurses have allowed their registration to lapse, and hence they are not included in the above figures. Demands for "refresher" nursing courses support this notion.

Another important facet of the work situation is turnover rates. Those in Alberta for various hospital groups are among the highest for graduate nurses in the country. The Canadian rate for all hospitals is 38.00.[3] The Alberta rate is the nation's highest with 50.34, Newfoundland follows with 50.12, Saskatchewan 47.47, Manitoba 43.94, while all the other provinces are well below 40 (Statistics Canada: *Hospital Statistics Vol. III,* 1972:211).

As far as the adequacy of the supply of nursing personnel is concerned, some indication is provided in Table 10. It presents vacancies reported to the Alberta Association of Registered Nurses, 1972-1975.

For the most part, there has been an overall increase, between 1972 and 1975, in the numbers of unfilled positions for registered nurses, nursing aides and nursing orderlies. It is difficult to determine what this increase in job vacancies means, although the increase in the number of hospital beds could be one contributory factor. Of significance also is the employment status of registered nurses in Alberta. In 1972, there were 2,502, or 21.5 percent of registered nurses in Alberta not employed in nursing (Canadian Nurses Association, 1973:9). In 1973 this number and percentage rose to 2,731, or 23.5 percent (Canadian Nurses Association, 1974:11).

[3]Personnel turnover measure is derived from the number of separations within an employing category during the reporting year, multiplied by two (as a percentage of the combined number of full time personnel in the categories, employed December 31st of both the reporting and preceding years).

Table 10

NURSING PERSONNEL VACANCIES REPORTED TO ALBERTA ASSOCIATION OF REGISTERED NURSES, 1972-1975

Category of Personnel	Month of January			
	1972	1973	1974	1975
Registered Nurses	95	211	198	352
Nursing Aides	52	66	83	198
Nursing Orderlies	16	42	20	61

SOURCE: Alberta Association of Registered Nurses. *Newsletter.* 31:4: April, 1975.

Concerning the shortage of nursing aides and orderlies, the following short review may offer a partial explanation. In 1972, 33 fewer nursing aides graduated from aide-education programs than during the previous year; in 1973, 46 less than 1972. An earlier discussion made reference to the high attrition rate (48.3 percent) in the nursing orderly program in Edmonton, during the period 1972 to 1973. Only 87 orderlies graduated from the Edmonton program during a three-year period.

One cannot refer to the retention of nursing personnel in the labour force without some comment relative to the predominance of females in this work category. In reviewing the literature pertaining to this issue, Anderson (1975:12-15) made a number of observations. Though her comments specifically relate to the employment of nurses in the labour force, many of her points may also apply to nursing aides.

Anderson states, since students attracted to schools of nursing are generally female and from middle-class backgrounds, the participation pattern of the nursing labour force is significantly affected by marriage and family responsibilities. The very fact most nurses are females suggests employing agencies should develop a more appropriate model of employment than the current one, which expects women to fit the male work-model. She concludes any attempt to remedy the nursing shortage by merely encouraging more recruitment, enlarged classes and increased numbers of nursing schools, is to treat only the symptoms and not the real problem.

Anderson warns of the dangers involved in forming a tight bureaucratic structure, so easy to do in a hospital setting, and of the impersonal nature of the hierarchy which may accompany it. She reminds readers that worker alienation can lead to frustration, a lack of productivity and instability, and in the end cause a high staff turnover. Anderson suggests the possibility that nurses are socialized to be compliant and dependent, and are therefore unlikely to rectify their own situation other than by leaving the work force.

A further factor mentioned by Anderson, as likely to contribute to poor performance and/or exit from the work force, is that of overutilization or inappropriate utilization of the nurse's skills. Too often new nurses have been placed in responsible positions too quickly. Employing agencies justify this action on the basis of need, but, Anderson claims, it is economically unsound in the long run, as often the nurse quits. She points out the work goals of most married nurses are focused on the maintenance of existing skills, rather than on advancement and growth. Since the majority of nurses are married women, the responsibilities assigned them need to be satisfying and meaningful, otherwise there will be little inclination for them to stay.

With respect to the same issue, Mitchell (1971:269-270) made the following radical recommendation:

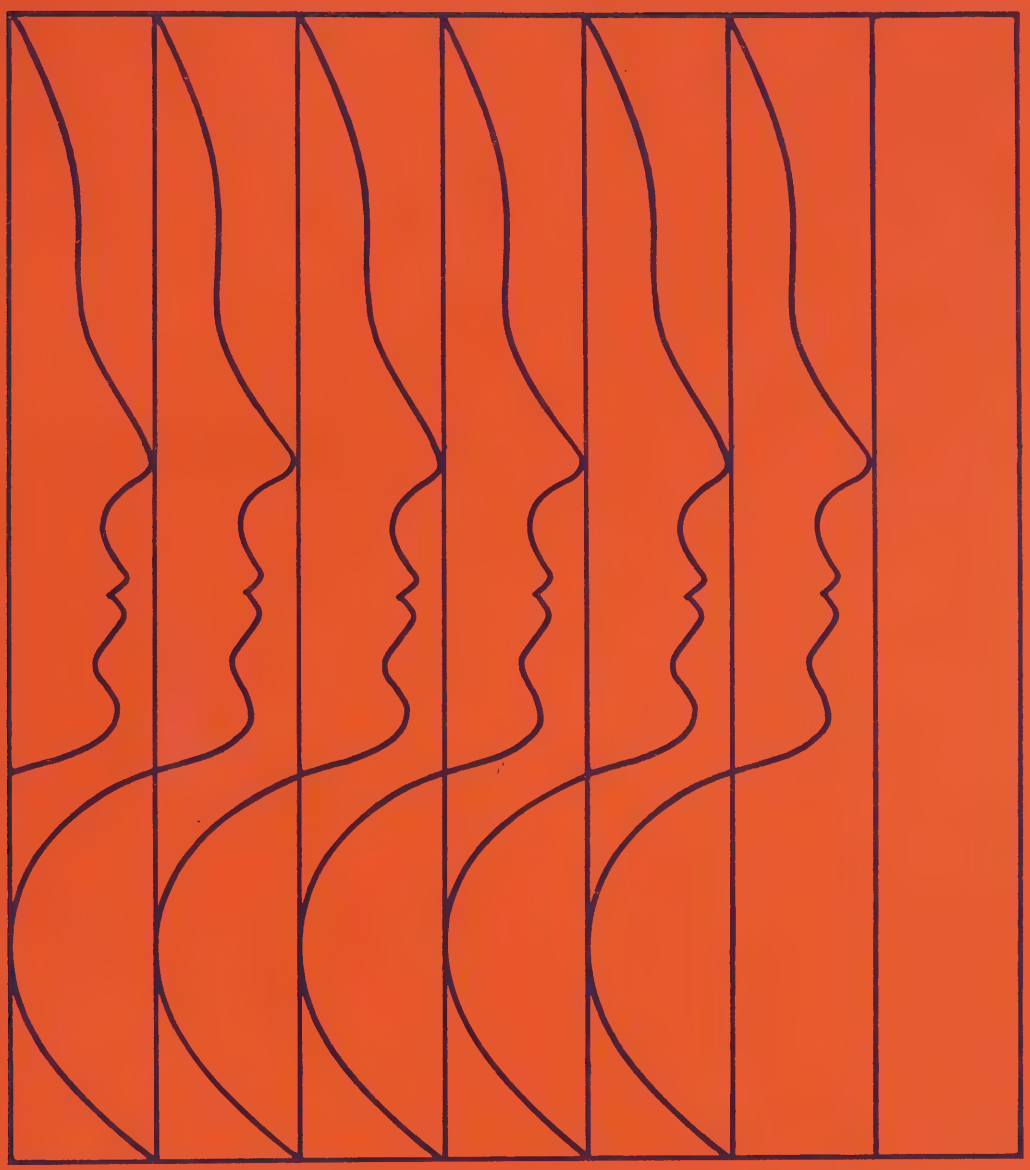
> Hospitals and health agencies should provide for better utilization of their personnel and resources while providing opportunities for

> nurses to pursue continuous professional careers. Health organizations should be advised to cease and desist from attempting to staff for maximum patient loads, they should, rather, use complementary staff who work less than an eight-hour shift. The professional organization should offer an employment service for nurses seeking to work on a limited basis in order to make the tasks of hospitals or health agencies in employing complementary staff easier. . . . Hospitals and health agencies should recognize that meeting the professional and individual objectives of the nurses is more important than filling vacant slots. . . .

As was stated earlier, hard data on which to develop testable hypotheses about nurses' participation in the labour force, are not readily available. Nevertheless, the Task Force believes comments, such as those reported above by Anderson and Mitchell, are sufficiently serious to warrant careful consideration by both employers and members of the profession. The present fragmentation, isolation and lack of articulation found in existing educational programs results in a nursing labour force which apparently is not meeting the needs of society. One would hope for an eventual prediction of what nursing manpower-mix is essential in terms of certain population groups.

Attempted solutions to the preparation of qualified workers must be directed towards the creation of a rational and organized system of training. The Task Force believes the comprehensive approach to nursing education, described in the next chapter of this report, will do much to improve nurse satisfaction as well as level of competence. This process will, however, be considerably advanced, if employing agencies also carry on a concomitant effort, to make the work of a nurse or nursing assistant as fulfilling and meaningful as possible.

Chapter 6



A SYSTEM OF NURSING EDUCATION

A SYSTEM OF NURSING EDUCATION FOR ALBERTA

Outlined in the foregoing chapters are implications which relate directly or indirectly to nursing practice and education. This chapter will not only outline a proposal for a nursing education system, but will also demonstrate how this system can contribute to meeting the health-care delivery needs and to improving the quality of the nursing labour force in Alberta.

The Task Force proposes that the nursing education system reflect two basic components, the preparation of professional nursing personnel and the preparation of para-professional nursing personnel.

The rationale undergirding this proposal relates to the fact that the practice-bases for these two groups are qualitatively different. Professionals are those who have extensive knowledge and skills, enabling them to make sound judgements concerning the overall, continuous management of patient care, whereas the para-professionals' practice is based on the application of knowledge in the execution of recurring nursing functions, having clearly defined limits.

These two categories are different not only in their practice-base but also in the type of educational process they experience. The professional is expected to conceptualize at a higher level of abstraction than the para-professional; the educational experience is more process-oriented than content-oriented; the professional has a cognitive style, enabling the use of the theory and content of science in imaginative ways while caring for patients.

On the other hand the para-professional is taught patterns of care, rather than the dynamics of care. The para-professional is not half-professional or imperfect professional, but rather an individual who is prepared to perform clearly defined functions in settings where she can have the guidance of professionals. Thus, the accompanying responsibility and accountability of the two groups also varies. Hopefully, the educational system will help future practitioners understand each other's roles and responsibilities, thus facilitating communication and coordination between the professional and para-professional. Though the identity and roles may differ, the concept of interdependence is primary.

These two components are seen as providing two distinct and separate "career ladders" in nursing. Although allowances are made for transferring from one "career ladder" to the other, emphasis is placed on counselling prospective nursing students prior to initial selection of a "career ladder" most appropriate to their motivation and ability. The professional segment, in the proposed system, prepares nursing personnel from the current diploma level through to the baccalaureate and the customary advanced-degree levels (Master's and Doctoral). The para-professional segment of the system prepares the category of nursing personnel the Task Force has chosen to call "nursing assistants". Both categories would be prepared within the system of advanced education.

PROGRAM DEVELOPMENT: PARA-PROFESSIONAL COMPONENT

Organizational Principles

The Task Force proposes certain principles to guide the development and continuance of para-professional nursing education in Alberta. These are as follows:

1. Completion of Grade X or an acceptable alternative as a minimum entrance requirement;

2. Amalgamation of the present Nursing Aide and Nursing Orderly programs into one ten-month program for the preparation of the Nursing Assistant;

3. Provision of opportunities for transfer to professional nursing through challenge examinations and evaluation of clinical performance, if admission standards are met;

4. Provision of opportunities following completion of the program for Registered Nursing Assistants to develop additional technical skills;

5. Recognition for the combined program under the auspices of the advanced education system;

6. Recognition of the fact that the legal responsibility for patient-care management rests at the professional level on a continuous basis, notwithstanding delegation to others for specific procedures;

7. Registration of graduates for practice at the para-professional level;

8. Establishment of an Alberta Registered Nursing Assistants Association;

9. Enactment by the Alberta Legislature of a statute known as the Registered Nursing Assistants Act, to supersede the existing Nursing Aides Act.

Location of Educational Programs

As proposed by the Task Force, programs for nursing assistants are planned to serve various regions in the province, depending on the need for such programs and on the availability of facilities as well as candidates. This does not presume the need to establish a multitude of nursing assistant programs. Rather it proposes a network which facilitates articulation and avoids unnecessary duplication of educational resources. Use of portable facilities could be considered for locations lacking necessary resources, such as classroom space, changing rooms and learning resource facilities.

Before establishing education programs for nursing assistants beyond those in Edmonton and Calgary, the following issues should be addressed:

1. The determination of present and future "manpower" needs for nursing assistants;

2. The acceptance of a standardized program for the preparation of nursing assistants;

3. The assessment of geographic areas with regard to the adequacy of teachers, "case" availability per student per unit of time, teaching and learning facilities, resources, and quality of clinical experience available for practica;

4. The possibility of correcting any deficits found in 3 above.

Curricula

The proposed para-professional program essentially includes the same curricula as those in the current nursing-aide and nursing-orderly programs (see Appendices D:1 and D:2, Chapter 5). The curriculum foci should be on patient self-care deficits related to activities of daily living, comfort measures, and patient safety, and on procedural skills defined as being within the area of para-professional nursing practice.

Thus, the basic preparation for the nursing assistant remains one which provides the cognitive, interpersonal and psychomotor skills presently taught in both the nursing-aide and nursing-orderly programs. These relate to: personal care; positioning and preparing patients for examinations; collecting specific specimens; application of specific heat and cold treatments; administering enemata; use of specified, sterile techniques; application of certain binders and bandages; specified disinfection and sterilization procedures; observing patient on intravenous therapy; isolation care techniques; and specific techniques associated with medical, surgical and maternity patients, newborn infants and children. This curriculum assumes nursing assistants have a role in helping people develop good habits, and in carrying out screening procedures for the detection of deviations from normal, for example, weighing children and testing vision.

Practicum experiences must reflect two major elements - the student's total needs in relation to his career objective, and the requirements inherent in the occupation he is preparing to enter. Recognizing the dearth of para-professionals in non-acute, clinical settings, the Task Force envisions 50 percent of the nursing assistants' clinical practice to be in auxiliary and/or rural general hospitals. This approach allows for greater diversification of the learning experience within the curriculum. It also prepares personnel to meet the manpower needs of all health facilities, be they primary, secondary or tertiary.

Following the completion of the Registered Nursing Assistant Program, opportunities to develop additional technical skills in such areas as orthopedic nursing, urological nursing, maternity care, mental health, operating room, emergency service, health screening procedures and home health care, should be made available. The development of these continuing education courses should be determined by the needs of clients, employers, and the practitioners themselves.

PROGRAM DEVELOPMENT: PROFESSIONAL COMPONENT

In view of the geometric expansion of knowledge, the complexities of modern man's health problems, the development of radical new medical technologies, the increased expectations of consumers for quality health care, the increased role of government within the health-care system and the development of various health-care delivery patterns, it becomes apparent that future professional health-care providers need a broad educational base. The Task Force envisions an increasing role for nurses in areas other than the traditional field of patient care. It sees them increasingly involved in such areas

as health education in the school system, in industry, in health agencies, and in the community at large; in promoting and maintaining the health of the community in a variety of ways; and in carrying out observations in the health field which will permit them to advise health agencies and governments on the necessary steps to be taken in providing a healthier environment and better health practices throughout the whole of the province.

Recognizing the above, the Task Force views baccalaureate preparation for nursing as the base for mastering a complex body of knowledge and as the vehicle to ensure continued professional growth and improved nursing practice. It is acknowledged that the goal of baccalaureate preparation for all professional nurses cannot be reached immediately, but the Task Force believes that such an objective should be attainable within a fifteen-year time frame.

It is therefore proposed that by 1990 all preparation for professional nursing practice be a baccalaureate in nursing. It is further proposed that this goal be accomplished on a phased basis to enable the system to adjust gradually to the increased educational requirement.

In addition to viewing a baccalaureate level of preparation as the basis for professional nursing practice, the Task Force believes that there should continue to be two routes to attaining that level. One route is a university-based program, and the other an articulated program between a university and other institutions of higher learning. In the following sections the essential elements of these two routes are described.

Minimum Preparation for Professional Nurses

Bearing in mind that the desired level of preparation for a professional nurse is the baccalaureate, the Task Force proposes the establishment of a minimum level of preparation to begin moving the system toward the desired goal. This would also address the anomalies described in Chapter 5 of a wide variation in length of programs preparing the same level of practitioner.

PROGRAM CONTENT. The Task Force identified four sub-issues regarding the content of this minimum (diploma) program:

1. The biological and behavioural sciences, and other support courses offered, must be equivalent to those offered in the university program.

2. The following support courses must be included: Anatomy, Physiology, Microbiology, Pathophysiology and Pharmacology, Sociology, Psychology, Communication, Abnormal Psychology, Growth and Development, and Nutrition.

3. Recognition must be given to the nursing student's need for a value system within which to make decisions. This may be provided through formal courses (such as Philosophy, Ethics, Religious Studies and English) and/or within the nursing content of a program. The development of a value system is of utmost importance when one considers the ethical concerns which confront the nurse of today and the future. These would include such issues as euthanasia, transplantation, birth control, addictive disorders, genetic manipulation, suicide and divorce.

4. Inclusion of learning experiences related to human relations, patient teaching, psychomotor skills, and an introduction to patient-care management and leadership skills.

LENGTH OF PROGRAM. In order to cover the content described above, the Task Force recommends that the length of the minimum program be 96 weeks. This is also consistent with the current regulations of the Universities Co-ordinating Council, which require a minimum of 22 months exclusive of vacation. No program should be less than this and any that exceeds the minimum should reflect a greater progression toward a Bachelor in Nursing degree. This is consistent with the general impressions that nurses, particularly in college and university programs, need more clinical practice, and that there is a seemingly excessive amount of clinical practice in hospital programs, which could be reduced into a more concentrated, meaningful learning experience.

As shown in Figure 3, the proposed program, composed of 400 hours nursing theory, 300 hours support courses, and 2,000 hours clinical practice, combines theory and practice in all the trimesters. This approach permits a direct application of the biological, behavioural and medical sciences to nursing practice, and also encourages future nurses to broaden their perspectives with respect to the health-illness continuum.

The third and sixth trimesters are, to a considerable extent, composed of clinical practica.

The first thirteen weeks of the seventh trimester (18 weeks: 13+5) is intended to provide students with an area of focus. This module called "Clinical Nursing" would allow the student to develop additional skills within a chosen high-interest clinical area, such as mental health, acute care, extended care, psychiatric nursing and maternal child nursing. Concurrently students would be enrolled in a Social Science and Physical Science option.

Subsequent to the above, students would be involved in a five-week work-study experience related to patient-care management and leadership skills within their area of concentrated study. It must be recognized that application of skills in management and leadership to complex situations requires further education through in-service programs offered by the institution employing nurses in such capacities. Other curriculum patterns could be developed by individual faculties within the context of the above proposed framework.

ENTRANCE REQUIREMENTS. In view of the rigorous nature of the proposed program, students would be expected to meet university entrance requirements or have the equivalent pre-requisites. However, there may be occasional extenuating circumstances, which require challenge examinations, adult privilege clauses, and periods within the non-university/university continuum for remedial purposes.

The Task Force is aware of various psychological tests being developed for assessing probability of student success and identifying areas where students need additional assistance. At the present time, however, matriculation standing is seen as the most reliable means of identifying probability

Figure 3

PROPOSED MINIMUM NURSING PROGRAM

Trimester (13 weeks)	Nursing Theory	Clinical Practice	Support Courses	Laboratory or Tutorial
1 2 3 4 5 6	To include concepts of: medical nursing, surgical nursing, obstetrical nursing, pediatric nursing, psychiatric nursing and clinical experiences in the appropriate settings.	Yes Yes 25–30 hrs./wk. Yes Yes 25–30 hrs./wk.	To include: physiology and anatomy, microbiology, pathophysiology and pharmacology, sociology (introductory), psychology (introductory), abnormal psychology, growth and development, communication, and nutrition.	
7 13 – weeks 27 hrs./wk. Total: 351 hrs.	CLINICAL NURSING MODULE "area of focus" or "concentrated study", e.g. mental health, acute care, geriatric care, extended care, cardiovascular nursing care, crisis care, etc. 3 hrs./wk. (39 hrs.)	16 Hrs./wk. (208 hrs.)	Social Science option 3 hrs./wk. (39 hrs.) Physical Science option 3 hrs./wk. (65 hrs.) pathophysiology, chemistry, biology	← 2 hrs./wk.
5 weeks	Application of Principles of Patient Care Management	25–30 hrs./wk.		
18 weeks				
TOTAL 96 weeks	400 hours	2,000 hours	300 hours	

of success. It was generally agreed that the institution must impose strict criteria, based on high academic achievement and other specified requirements, to select students for admission into a nursing program.

The Task Force also recognizes the responsibility and the right of the faculty to require withdrawal from the program of those students whom they assess as failing to meet the academic or clinical criteria of the program.

Additional Desirable Preparation

The previous section described what the Task Force believes should be the minimum level of preparation for registered nurses at the present time. The difference between that minimum and the desired baccalaureate level can be conceptualized as consisting of three modules of thirteen weeks each: community health nursing; the instructional process; and primary care. Figure 4 presents an overview of these modules.

MODULE 1. Community Health Nursing would address such issues as family and community diagnosis, environmental health probelms, health-care delivery, and the nursing role within these. Support courses would include Principles of Learning, Epidemiology, and Behavioural Statistics.

MODULE 2. The Instructional Process would focus on Methods of Instruction, Nursing Issues, and Principles of Administration. Teaching patients and families would include spontaneous and planned instruction to individuals and groups. Concurrently, students would enroll in an upper-division elective, covering such areas as psychology of aging, interpersonal relationships and counselling.

MODULE 3. Primary Care would include courses in health education, health promotion and maintenance, nursing research, administration in patient care, and issues and trends in the delivery of health care. This module would include physical assessment skills and clinical management of individuals and families along the health-illness continuum. Concurrently, students would enroll in a three-hour upper-division elective.

Obviously, all these modules would have both a didactic and practicum component. It is also implicit that such a program would integrate mental health, deviant behaviour (psychiatric nursing) and social concerns throught the curriculum. These modules would be planned in a way which allows students to take each as time, financial ability and other factors permit. More nurses in the province could be served if universities arranged for other educational institutions to offer some of these modules in regions beyond the university centres.

Joint planning between nursing service and nursing education representatives from non-university and university institutions for the development of these modules should begin as soon as possible. In such planning sessions variations of the above curriculum outline might be developed within the same framework.

Phasing of the Expanded Educational Requirement

As indicated earlier, the Task Force proposes that the goal of achieving a

Figure 4

PROPOSED ADDITIONAL PREPARATION BEYOND THE MINIMUM PROGRAM

Module 13 weeks	Nursing Theory	Nursing Laboratory or Tutorial	Clinical Practice	Support Courses	Laboratory or Tutorial
Module 1 COMMUNITY HEALTH NURSING 26 hrs./wk. Total: 338 hrs. Required by all Alberta Nurses by 1985	Community health nursing. 3 hrs./wk. (39 hrs.)	2 hrs./wk. (26 hrs.)	← 10 hrs./wk. (130 hrs.)	Principles of Learning 3 hrs./wk. (39 hrs.) Epidemiology 3 hrs./wk. (39 hrs.) Behavioural Statistics 3 hrs./wk. (65 hrs.)	
Module 2 THE INSTRUCTIONAL PROCESS 23 hrs./wk. Total: 299 hrs. Required by all Alberta Nurses by 1990.	Methods of instruction 3 hrs./wk. (39 hrs.) Nursing issues 3 hrs./wk. (39 hrs.) Principles of administration 3 hrs./wk. (39 hrs.)	2 hrs./wk.	Practice Teaching ← 3 hrs./wk. (65 hrs.)	Option 3 hrs./wk. (39 hrs.) Psychology (aging) 3 hrs./wk. (39 hrs.) Interpersonal Relationships Counselling Communication 3 hrs./wk. (39 hrs.) (could be interdisciplinary course)	← 2 hrs./wk.

Figure 4 (continued)

PROPOSED ADDITIONAL PREPARATION BEYOND THE MINIMUM PROGRAM

Module 13 weeks	Nursing Theory	Nursing Laboratory or Tutorial	Clinical Practice	Support Courses	Laboratory or Tutorial
Module 3 PRIMARY CARE (Module 1, 2 & 3 are prerequisite) 26 hrs./wk. Total: 338 hrs. Required by all Alberta Nurses by 1990.	Health education 3 hrs./wk. (39 hrs.) Health promotion and maintenance 3 hrs./wk. (39 hrs.) Nursing research 3 hrs./wk. (39 hrs.) Administration in patient care 3 hrs./wk. (39 hrs.) Issues and trends in the delivery of health care (could be inter-disciplinary course) 3 hrs./wk. (39 hrs.)	2 hrs./wk.	←Health education 6 hrs./wk. (104 hrs.)	Option 3 hrs./wk. (39 hrs.)	

baccalaureate level of preparation for all nurses be phased over a period of fifteen years. If possible the time frame should be shortened, but certainly not extended.

PHASE 1. The first phase would consist of the period from 1975 to 1985 during which the minimum (diploma) program would be firmly established. It would be required by 1980. Also in this phase, the three additional modules would be developed for those students who wish to take them as part of their own professional upgrading.

PHASE 2. The second phase would begin in 1985 and extend to 1990. During this period the module in community health nursing would become a requirement for nurse registration in Alberta. In 1990 the remaining two modules would be added as a requirement for nurse registration, and thus the goal of the baccalaureate will have been reached.

A summary of the proposed time frame is shown below:

Program Content	Required By	Authority to Issue Certificate of Completion of Program for Eligibility to Write Registration Examinations
96-week diploma program	1980	School offering program
Community Health Nursing Module	1985	University only
The Instructional Process Module	1990	University only
Primary Care Module	1990	University only

The above schedule implies that by the year specified, Alberta trained nurses will not be eligible to write their registration examinations until completion of the required module or modules. Attention is drawn to the 1985 target date, when only the university nursing schools will have the authority to issue certificates of completion of programs and provide eligibility for writing nurse-registration examinations.

After 1985 reference to any non-university program would indicate the decentralized portion of the baccalaureate program rather than a diploma program. In other words, these programs would become components of an articulated baccalaureate program.

Some arrangements are required to enable graduates outside the province to achieve

Alberta nurse registration. This is an important issue. In 1973, for instance, 677 nurses graduated in Alberta and obtained nurse registration, while an additional 425 from other provinces and countries became registered nurses in this province (Canadian Nurses' Association 1974:60).

These non-Alberta graduates may or may not meet the proposed educational standards set by Alberta. Concomitantly, appropriate arrangements need to be made for continued annual registration of those nurses who were registered in Alberta prior to 1990 within the provisions and bylaws of the Registered Nurses Act.

TRANSFER OF CREDIT. The collaboration described above, between non-university and university programs to assure graduates a means of securing baccalaureate level preparation, depends upon the resolution of various transfer issues. For this reason the Task Force believes that it would be appropriate for the Provincial Council on Admissions and Transfer to address these issues as a priority. This is seen to be consistent with the terms of reference of the Council as reported in Appendix E:1. The major issues would be the following: (a) the possibility of a total non-university nursing program being equivalent to a specified amount of the baccalaureate program (this eliminates the need for course-by-course equivalence); (b) the transfer of nursing students into other health-related occupations, or the transfer of students from such occupations into nursing. Articulation among the educational institutions would be enhanced by the preparation of well-defined curricula outlines for each course, spelled out in terms of measurable objectives that can be used as a basis for transfer agreements, and by the use of proficiency/equivalency testing programs when applicable.

University-Based Baccalaureate Program

The foregoing discussion has presented the Task Force's proposal to provide baccalaureate level preparation to nurses by means of an articulated program. In addition to this route to the baccalaureate degree, the Task Force maintains that students should have the alternative of entering directly into a university-based program.

The Task Force did not address itself directly to the curriculum pattern of the latter program, except to assert that it should be consistent with this report's recommendations relating to the professional curriculum. In particular, it is stressed that the program should reflect the changing trends in health-care delivery and the evolving role of nursing discussed elsewhere in this report.

A major advantage of having both articulated-baccalaureate and university-based baccalaureate programs is the flexibility and creativity which can be fostered in faculties as they develop new and dynamic approaches to curriculum development. The philosophy, conceptual framework and product descriptions of the two programs could be quite different. Thus, in the university program the integration of mental health, social concerns, physical assessment skills and the decisional role of the nurse could be promoted early in the student's role induction, through a balance between general education and nursing courses and through a judicious sequencing of nursing courses. This integration might be more difficult to achieve in the articulated program.

Different options along episodic or distributive tracks could be developed. This would warrant different types of course material and learning experiences for the two groups. The organizational strands of one program might move from wellness to illness, whereas the other's might move from illness to wellness with clinical resources reflecting this approach.

The research environment of the university could also influence the quality of scholarship and commitment to self-education. This implies that the university-based programs might have greater leverage in preparing nurses who demonstrate an attitude of intellectual curiosity, flexibility, reflection, a willingness to risk and an ability to identify various alternatives in the analysis of issues which concern nursing.

In developing curricular patterns which will reflect the evolving role of nursing, faculties should keep in mind the factors developed by the Alberta Association of Registered Nurses and presented in Chapter 3. Briefly, these included the importance of nurses addressing themselves to: the personal health goals of individuals and families; the developing health-care system; interdisciplinary approaches to care; the decisional role of the nurse; primary care; the preparation of nurses for administrative and educational leadership; research and specialized areas of clinical practice; the development of nursing standards and the systematic evaluation of quality of health service rendered; the accountability of nursing; the legislative base for nursing practice; patient consumer rights; and the economics of health care.

The Standards of Practice developed by the American Nurses Association (1974) and presented in full in Appendix E:2 should also be kept in mind by faculties as they deliberate the development of relevant and dynamic curricula. These standards are:

I – THE COLLECTION OF DATA ABOUT THE HEALTH STATUS OF THE CLIENT/PATIENT IS SYSTEMATIC AND CONTINUOUS. THE DATA ARE ACCESSIBLE, COMMUNICATED AND RECORDED.

II – NURSING DIAGNOSES ARE DERIVED FROM HEALTH STATUS DATA.

III – THE PLAN OF NURSING CARE INCLUDES GOALS DERIVED FROM THE NURSING DIAGNOSES.

IV – THE PLAN OF NURSING CARE INCLUDES PRIORITIES AND THE PRESCRIBED NURSING APPROACHES OR MEASURES TO ACHIEVE THE GOALS DERIVED FROM THE NURSING DIAGNOSES.

V – NURSING ACTIONS PROVIDE FOR CLIENT/PATIENT PARTICIPATION IN HEALTH PROMOTION, MAINTENANCE AND RESTORATION.

VI – NURSING ACTIONS ASSIST THE CLIENT/PATIENT TO MAXIMIZE HIS HEALTH CAPABILITIES.

VII – THE CLIENT'S/PATIENT'S PROGRESS OR LACK OF PROGRESS TOWARD GOAL ACHIEVEMENT IS DETERMINED BY THE CLIENT/ PATIENT AND THE NURSE.

VIII – THE CLIENT'S/PATIENT'S PROGRESS OR LACK OF PROGRESS TOWARD

GOAL ACHIEVEMENT DIRECTS REASSESSMENT, REORDERING OF PRIORITIES, NEW GOALS SETTING AND REVISION OF THE PLAN OF NURSING CARE.

The acceptance of these standards by the education and service sectors would do much to bridge the gap between the "ideal" and the "real" so that future practitioners can contribute to society's health-care delivery needs in such a fashion as to recognize nursing as a viable and efficient service.

Graduate Education

Having addressed itself to the educational preparation of the generalist in nursing, the Task Force turned its attention to graduate education. No attempt was made to specify the exact nature of the content of nursing programs leading to Master's and Doctoral degrees. However, implicit in the whole area of graduate study are two assumptions: (1) the candidate has achieved distinction in the basic areas of a discipline to the level of a university degree; and (2) capacity and motivation are sufficient to permit research and further study with a degree of independence.

MASTER'S DEGREE. Preparation for a Master's degree usually includes three main elements: study of graduate-level courses related to a select program; review of the literature in the area of specialization; and finally, concentrated research on a defined topic.

Graduate programs in nursing may focus on any one of four distinct areas of study:

1. Clinical nursing of a specialized type, to ensure competent nursing service to patients. Broad clinical areas of specialization include: (a) acute medical-surgical nursing with sub-specialities in intensive-care nursing (cardio-thoracic, renal, neurological and neuro-surgical), operating room nursing, recovery room nursing, and emergency room nursing; (b) advanced practical obstetrics with sub-specialities in neonatal nursing and high-risk pregnancies; (c) paediatrics; (d) geriatrics within extended care facilities and hospitals; and (e) psychiatric-mental health nursing.

2. Community health nursing, involving research in community health care and the role of the nurse in fostering and maintaining good health in the community. Areas of specialization within community health include the following: (a) parental-child care; (b) in-home services; (c) community mental health or psychiatry; (d) family-practice nursing; (e) school health; (f) industrial health; (g) geriatric care; (h) health planning and community organization; (i) health education; (j) primary care; (k) epidemiology; and (l) care of the chronically ill. The above can be studied from the functional perspective of consultant, teacher, practitioner, administrator, or researcher.

3. Clinical nursing administration in a large hospital or health unit.

4. Nursing education.

An additional point the Task Force believes important to emphasize is the need for a massive upgrading of nurses, from basic diploma status to basic degree status, to achieve a concomitant increase in personnel

who can be prepared at the Master's and Doctoral level.

DOCTORAL DEGREE. Candidacy for a Doctoral degree calls for a substantially higher level of competence and motivation than for a Master's degree, a broad familiarity with the profession of nursing in many of its aspects, and a capacity and willingness to undertake original research in great depth. The areas of study are similar to those suggested for the Master's degree.

For some time to come, the Doctoral level in nursing will probably remain a highly academic program with research orientation. This requires applicants with very high intellectual ability, superior verbal skills (written and oral), a scientific orientation toward their profession, and specific analytical and collational skills (for example, statistical inference and report writing). At some future date, one may expect a Doctoral program of a more "applied" type, with specific degrees to match, for example, Doctor of Jurisprudence (Harvard), Doctor of Education (Stanford), Doctor of Science, Doctor of Nursing.

GRADUATE NURSING EDUCATION IN ALBERTA. With respect to graduate nursing in Alberta, it was reported in Chapter 5 that the province suffers a substantial deficit. The Task Force views this situation as extremely serious and, therefore, feels that strong support must be given to the Master's program in acute care nursing which begins at the Unviersity of Alberta in the fall of 1975. Other graduate programs must be developed at the earliest possible time. The Task Force also recognizes the urgency to increase the supply of nursing educators with advanced degrees and considers this a top priority.

To implement the above, special funds should be made available to university faculties of nursing so that nurse faculty members holding Doctoral degrees can be appointed. This would enable faculties to offer Master's degrees in nursing in the four areas of specialization previously described. The Task Force also believes that prospective candidates for a Doctoral degree in nursing should be encouraged to pursue this program through the provision of grants or bursaries. To this end, beginning immediately and for a minimum of five years, at least three Doctoral candidates in nursing should be assisted each year to pursue studies in clinical nursing, nursing education, nursing administration and/or nursing research. Such should contain a "return to province" requirement.

INSTRUCTIONAL ISSUES

Having developed its proposals for structuring the professional and para-professional components of the nursing education system, the Task Force turned its attention to three instructional issues which it considers significant for developing quality educational programs at all levels. These issues are discussed below.

Curriculum Evaluation

The Task Force believes that teaching and learning can be enhanced through the establishment of procedures to provide curriculum evaluation and feedback. Guidelines for such review and restructuring would include the following:

1. Analysis of the philosophy, conceptual framework, purposes and objectives of the program;

2. Evaluation of the rationale for organizing the nursing major and for allocating credit for nursing courses;

3. Correlation of learning experiences and methods of instruction with the program purposes and objectives;

4. Organization of liberal and professional education in terms of progressive development of knowledge and skills;

5. Development of clearly stated competency based objectives for courses, taking into account the conceptual framework, the organizing strands, and the expected achievement levels within the program;

6. Establishment of realistic entry requirements and criteria for student selection;

7. Identification of minimum staffing levels, space, and equipment for basic science courses;

8. Determination of minimum staffing levels to ensure quality in academic and clinical nursing instruction;

9. Assessing the relevance of the curriculum to new demands in primary care and mental health; and the

10. Examination of theory and practice in terms of providing learning experiences to professionals which develop decision-making, independent judgement, leadership skills, and research skills.

The Organization of Teaching-Learning: Modules

The above discussion of curriculum evaluation stresses the importance of relating program content to desired outcomes. One means of facilitating such articulation is the use of modular instruction, which in the field of nursing education can provide considerable advantages to patients, students, teachers and nursing service personnel. The modular system would also be a good test of the flexibility (or rigidity) of educational institutions, and their ability to introduce innovations aimed at increasing competence in the practice of the professions or other applied sciences.

Kuhns and Martorana (1974: 431-432) point to the characteristics of conventional patterns, whereby students and faculty convene for classes meeting three or four 50-minute hours for fifteen or sixteen-week terms. In contrast, in some "time modules" students take only one course in intensive two- to four-hour sessions a day, four or five days a week. "Even though there may be thirty students in a class, such constant inter-action means that almost from the beginning the instructor knows every member of a class as a person. He knows who is making progress, in which areas, and often for what reasons. For the unprepared student there is no place to hide".

Using this approach,nursing students could take an intensive course in a given subject, with concurrent or subsequent

practicum in the corresponding clinical setting with the guidance of the teacher-practitioner. Such an arrangement would provide the student with a concept of continuity of care, an involvement with the patient's family, and a sense of nurse-identity and accountability. This may even help to reduce the criticism of "fragmentation" sometimes levelled at nursing service, by enabling hospital administrators to include students in specific units without disrupting either the care itself or the regular staff.

In no way should the above be interpreted as a return to "the block system" in nursing education, nor as the "exploitation of students for service". Definite criteria for the quality of the setting to provide a satisfactory student practicum, and for competence of teacher-practitioners, must be established.

Some colleges and universities offer intensive courses in disciplines without a practice component. Students from a variety of disciplines may wish to take these courses with nursing and other health-discipline students. Possibly, faculty members would enjoy intensive teaching, followed by intervals with less or no teaching responsibilities, when they have uninterrupted time for course planning, research and the like. Such courses could provide welcome variations and valuable experiences to both students and faculty.

Organization of Faculty

The kind of collaboration, between nursing education and nursing service required to provide students with the learning opportunities described above, is not always readily apparent. In this connection, MacPhail (1975:32-33) made the following comments at a nursing workshop in Ottawa:

> There is strength in unity, and nursing's major problem is lack of unity. A barrier exists between nursing education and nursing service. The new graduate is not prepared for the "real" world. Nursing service does not provide opportunities for new graduates to function as they have been taught. Nurses' talents and time are poorly used. There is a paucity of leadership in nursing. Anti-intellectualism exists in nursing.

One of MacPhail's approaches to promoting collaboration between nursing education and nursing service is:

> . . .to develop an interinstitutional relationship, whereby competent nurse educators could have influence on the quality of nursing care in the settings used for students' practice, and hence on the learning climate provided students. At the same time, capable educators and administrators in nursing service could work together toward their common goals, even though their primary goal differs.

At Case Western Reserve, MacPhail and her associates initiated a joint education and service endeavour to "develop and test new patterns of interinstitutional relationships and to effect changes in the patterns of organization and functioning within each of the two institutions". The patterns were designed to (1) enhance the quality of nursing care, (2) provide an exemplary learning climate for nursing students and staff, (3) increase the spirit of inquiry and research in nursing practice, (4) improve the use of human and material resources, and (5) promote collaboration among health

professionals.

Case Western Reserve developed three major types of joint appointments to enhance relationships and collaboration in nursing service and nursing education. These shared appointments, clinical appointments and associate appointments, are described in Appendix E:3.

Dean Christman has on his nursing faculty at Rush University College of Nursing practitioner-teachers who care for patients regularly. He strives to give practitioner-teachers a "50–50" clinical-educational experience.

Similar kinds of models are now operative in other university centres in the United States. Dean de Tornyay requires evidence of clinical competence for promotion of clinical-nursing faculty members at the University of California Centre for Health Sciences in Los Angeles. She believes that "most leading schools are moving toward reuniting practice and education", and applauds the change. Lysaught, formerly Director of the National Commission for the Study of Nursing and Nursing Education in the United States, states "today we do not appoint instructors to the faculty without the understanding that they will devote some time to clinical care" (Editorial. *Journal of Obstetrical and Gynaecological Nursing*, January–February, 1975:10–11).

A group of nursing service directors at a Task Force meeting accentuated the need for increased communication and cooperation between nursing service and nursing education. Because of the nature of their responsibilities it is easy for nursing teachers to lose touch with changes in and realities of the world of work.

Avoiding this "ivory-tower" situation is one of the reasons why the Task Force supports the concept of joint appointments.

UTILIZATION OF CLINICAL RESOURCES

The kinds of collaboration between nursing education and nursing service discussed above would do much to alleviate a problem which greatly concerned the Task Force – namely, the access to and utilization of clinical resources by nursing students.

The members were most disturbed to learn from several sources of an apparent lack of clinical facilities in Alberta, particularly for some college programs as well as for both university programs.

Some factors which contribute to the apparent shortage of clinical facilities are: failure to consider various alternative means and kinds of resources; less than efficient and effective use of resources available; rigidity in requests for resources; failure on the part of all concerned to discuss, plan, compromise, collaborate and coordinate; failure to convince the administrators of health-service agencies of the desirability of participation in educational programs; and competition rather than cooperation between the various segments of the nursing and related health programs.

The Task Force realizes there is no easy solution to this problem, but concluded that much of the difficulty stems from an acceptance of a false division between nursing education and nursing practice. On the service side, educational institutions are often seen as intruding in some way, while on the educational side, the service institution is frequently perceived as resisting. As long as such antagonistic positions are maintained, the quality of nursing education and nursing service is certain to suffer. The Task Force has repeatedly emphasized the importance of perceiving nursing education as a joint effort between nursing service and nursing education. The separation of nursing service and nursing education over the years has had adverse results, as described by MacPhail (1975:33),

> Nursing educators and nursing service administrators were, and many still are, hypercritical of each other's policies and practices, to the detriment of both patients or clients and students.

What is required is a new concept to banish the old stereotypes — a concept which substantiates the training of workers as belonging to both institutions. The service institutions must recognize that the provision of clinical training to those who will be nurses in tomorrow's workforce is both an obligation and a privilege. Educational institutions, on the other hand, must recognize the need for flexible programming in nursing schools, so students can take their clinical training within the rhythm of the service setting. It is just as unreasonable for a nursing school and its faculty to desire clinical experience on a nine-to-five, Monday-to-Friday basis, as it is for a service institution to say that its facilities are only available to a given school between 7 p.m. and 9 p.m., Saturday and Sunday. Such approaches to clinical practice miss the entire point of making nursing education essentially a partnership arrangement between the school and the service setting, and ignore the fact that nursing is a profession within the human service arena.

Genuine collaboration between educational and service institutions will aid in the preparation of nursing graduates who can provide competent care, find employment, and develop their potential in nursing practice. Advisory Committees may, through comments and suggestions, help foster a feeling of common concern and common effort between the two institutions, although the final decision on educational policies must remain the prerogative of the educational institution.

Some educational and service institutions find value in having coordinators who are familiar with and respond to all the requests for clinical-practice facilities. Others stress the importance of discussion, planning and compromise at the patient/client-care level of administration. Some combine these two approaches.

In an attempt to coordinate and equitably share the clinical resources for health-discipline education available in British Columbia, the Educational Planning Committee of the British Columbia Medical Centre has appointed an advisory committee, to, among other things: (1) compile an inventory of existing teaching resources in clinical facilities; (2) describe the present and desired use of clinical facilities by educational programs; and (3) develop a model to match the identified learning experiences with the appropriate clinical resources. In Ontario, a

number of years ago, assessments were made of, and priorities were established for, the supply and demand of clinical practice requirements for nursing educational programs in a number of provincial regions. The Task Force believes that similar approaches in Alberta would be beneficial.

As a result, the Task Force recommends that there be effective regional or local agreements among the various nursing programs and health-care agencies for cooperative utilization of available primary, secondary and tertiary clinical facilities, taking into consideration established priorities for nursing education development. Allocation of clinical facilities could be rationalized by examining such issues as: (1) prospective enrollments for nursing schools in an area; (2) assessment of adequacy and effective use of present clinical facilities; (3) alternative clinical facilities; and (4) the setting of priorities for the long term utilization of facilities. It was also suggested that the incremental cost of integrating nursing education and service programs (including the cost of release time for supervision) be recognized and subsidized by the government.

The Task Force also endorses the suggestions contained in the National League for Nursing's publication, *Arrangements Between an Institution of Higher Education and Agencies which Provide Learning Laboratories for Nursing Education* (1973). The League's statements are reproduced in Appendix E:4.

From data presented to the Task Force, some nursing education programs in Alberta appear to contain an excess of clinical practice. Perhaps more equal practica among the various programs would lead to a more equitable distribution for all. This, combined with the trend in nursing education programs toward expansion of clinical practice areas beyond the usual Monday-through-Friday experience, could relieve unequally distributed demand on clinical teaching-learning units.

Another point which needs to be considered is the issue of effective use of clinical experience. Are the practicum experiences planned in such a way as to promote the integrative aspects of nursing and to limit to clinical practice those things which cannot be taught anywhere else? Many times clinical settings are used to teach and evaluate competencies which could be achieved more efficiently and at less cost elsewhere. This in turn would force all nursing educators to define very specifically those learning experiences which will likewise produce competent practitioners.

In the past clinical experiences within nursing curricula have been primarily located within secondary and tertiary care settings. Broadening the training base by including exposure to all facets of health care, in rural areas as well as the urban centres, will also relieve the demand on the traditional institutional settings. The evolving role of nursing, in meeting the patient-care delivery needs of the future, necessitates utilization of the entire health-care spectrum-services, facilities and human resources.

Diversification of clinical resources would be increased even more through the development of a variety of instructional methods and learning resources (cable

television, auto-tutorial-self-pacing-packages, tele-conferences, portable facilities, satellite programs). This would also improve the availability of educational programs in outlying areas.

PROGRAM DEVELOPMENT: QUALITY ASSURANCE

The discussion so far in this chapter has been concerned only with that portion of nursing education which can be called pre-service. By this is meant that education which has prepared the nurse or nursing assistant to go to work at the level of competence described in Chapter 4. It is one thing, however, to be a nursing student whose knowledge and skills are being carefully developed through a planned program of instruction and practice, but it is quite another to be a graduate working as a responsible member of a team.

In-Service Education, Orientation Programs and Refresher Training

The Task Force believes the transition between the pre-service and service program should be made smooth and realistic, through a conscious and sustained effort on the part of service institutions in providing programs of orientation and in-service education.

Kramer (1974:vii–viii), in the book *Reality Shock*, reports on eight years of study and research on the conflicts and dilemmas of new nursing graduates from three-year diploma, associate-degree and/or baccalaureate programs. "Reality shock is a term used to describe the phenomenon and the specific shocklike reactions of new workers, when they find themselves in a work situation for which they have spent several years preparing, and for which they thought they were going to be prepared, and then suddenly find that they are not." Three major conflicts were identified (Kramer, 1974:193):

> 1. The difference between systems of work organization (the professional system being the predominant system in school, the bureaucratic being the predominant system of organization at work) and the resulting difference between rewards and sanctions in school and work.
> 2. The difference between the school world of explicit expectations and the work world of implied expectations.
> 3. The difference between the school cosmopolitan view and the work world's localite view.

In addition to the above common conflicts Kramer (1974:196) states that,

> there are other differences between work and school that were expected to engender conflict of a more individualistic nature, depending on the educational background and work milieu:
>
> 1. Clinical uncertainty or ambiguity.
> 2. A competency gap.
> 3. The generation gap.
> 4. The constancy of time and time orientation of work.
> 5. Subcultural differences between institutions.
> 6. Racial conflicts as they affect work performance.

The above phenomenon has implications for both pre-service and in-service education. However, due to the significance of this problem in the service setting, the importance of in-service education is highlighted. Much

can be done by such personnel as staff nurses, head nurses, supervisors, administrators, and in-service nurse educators, to cushion the shock and thus decrease the number of disillusioned nurses who leave the work force.

In-service education includes activities designed specifically to help the individual function within a prescribed setting. Generally, this type of education is institution-oriented. Typical in-service programs cover such topics as: general orientation to the setting; review of cardiopulmonary-resuscitation; policies and procedures for the administration of intravenous medications; introduction to the use of new equipment; and common institutional policies and procedures. These programs can be developed either at the unit level or by a central department. Approaches vary with type, location and size of institution.

The adequacy of in-service programs for college graduates in Alberta has been studied by Steed (1974). She found that 30 percent had received no in-service training, 30 percent felt that their in-service was insufficient and 35 percent indicated that the in-service was of fair quality. This is only one example; however, it certainly seems to reflect a need to examine closely the effectiveness of in-service programs in Alberta.

In addition to in-service programs, refresher training is also necessary to maintain the quality of nursing manpower and to allow non-practicing nurses to return to the labour force. These courses should be planned in terms of two general areas: upgrading the knowledge-base related to the basic sciences and upgrading the communication and technical skills of nursing practice.

Continuing Education

The in-service education programs described above are important and critical aspects of an effective nursing education system. Beyond this activity, however, lies that other important facet of the nurse's world, which the Task Force has chosen to call "continuing education". By this is meant a form of education the American Nurses Association (1974:1) has described as:

> . . .a life long learning process which builds on and modifies previously acquired knowledge, skills and attitudes of the individual.
>
> The content and structure of Continuing Education must be flexible in order to meet the nursing practice needs and career goals of nurses.

Continuing education includes programs/activities which increase the nurse's science-base for professional practice at the highest level of competence. The information gleaned is usually applicable to multiple settings. Examples of continuing education programs are: a review of respiratory physiology; the components of patient assessment; physical assessment of patients in a critical care or ambulatory setting.

In-service and continuing education are seldom easy to separate. A large area of overlap will always exist, as the application of new procedures and information often calls for new learning in one form or another. Regardless of where or how the learning takes place, professional growth increases the overall quality of professional activity.

A program sponsored by an educational institution is not the only form of continuing

education, as is pointed out by Abdellah *et al* (1972:335). Others mentioned are: self-directed study; courses prepared and provided internally by health agencies, meetings, seminars, workshops, and conferences sponsored by professional organizations concerned with health care.

A continuing education program should: (1) have administrative support; (2) be an identifiable unit within the organizational structure of the institution; (3) provide the director of continuing education with authority commensurate with responsibility; (4) have an adequate and separate budget for the program; (5) have appropriate physical facilities; and (6) have sufficient numbers of prepared faculty and support personnel.

It is possible the larger health institutions can provide these requirements, but smaller ones will need financial and other assistance. This is another example of the dire need for more interaction between health-service agencies and educational agencies. Joint planning, implementation and evaluation of continuing education programs, and joint service-education appointments, such as those discussed earlier in this report, should facilitate this collaboration and provide "trade-offs" which will cement working relationships.

The American Nurses Association's definition, assumptions, and goals of Continuing Education are presented in Appendix E:5. The responsibilities of the nursing association, the individual, and the faculty, as delineated by the American Nurses Association, are set out in Appendix E:6. This document assigns to administrators of health-care agencies a "responsibility to the health-care recipient to promote Continuing Education for nursing personnel." It quotes (p. 5) Standard V of the Joint Commission on Accreditation of Hospitals: "There should be continuing training programs and educational opportunities for the development of nursing personnel".

To meet these responsibilities the employer should, in the view of the American Nurses Association: (1) establish and publicize policies relating to personnel participation in continuing education; (2) provide learning opportunities under established guidelines; (3) make available time and/or finances for attending continuing education offerings outside the institution or agency, when appropriate; (4) assist in the implementation of appropriate concepts obtained through continuing education activities; (5) provide an opportunity for the nurse to share with colleagues the information gained from continuing education activities; (6) provide for recognition of participation in continuing education activities; and (7) identify the learning needs of nursing personnel, and refer them to the appropriate educational facilities.

The Canadian Council on Hospital Accreditation also substantiates the need for staff development. Their position is reported in Appendix E:7.

Consistent with the above position the Task Force strongly supports an enlightened policy of educational leave and financial support for maintaining and increasing the quality of the nursing labour force.

SUMMARY

This chapter has outlined a framework for the planning and coordination of nursing education in Alberta. What has been described is a multi-dimensional system made up of carefully articulated parts. The establishment of functional relationships among the various components of this system is crucial to the future preparation of professional and para-professional nursing personnel and their role in meeting health-care delivery needs. The system described has taken into account present practice and laid the base for future expansion of knowledge, as well as addressing continuing education needs of nursing personnel. Thus, future practitioners should be more oriented to Lalonde's and Robertson's concepts of health; more cognizant of the scientific and humanistic approaches to care; more effective in motivating individuals, families, and communities to make appropriate health-related decisions; and more effective health-team members.

All of the issues related to professional education, with which this chapter has been concerned, are capsulized by Schein (1972:130-131). He states that the professional school should be organized around modules which integrate basic and applied sciences and professional skills. He stresses the need for faculty to be expert in learning theory, team work and interpersonal skills, while he believes that the administration should be flexible and encourage heavy involvement from students, faculty and future employers. Lastly, the educational program, its output, and the effectiveness of the profession itself, must be monitored continuously through self-diagnosis and evaluation. The Task Force endorses these principles and contends further that they are as much applicable to para-professional education as to that of professionals.

The uncertainties and challenges of the future require creative, concerted efforts on the part of all those concerned with nursing education. Success will depend on how all sectors transcend their own particularities in view of an overall commitment and involvement to nursing within an open system. Their responses to the issues discussed in this report must reflect adaptability, creativity and a willingness to experiment in the face of a constantly changing social and physical environment.

Chapter 7

MONITORING THE NURSING EDUCATION SYSTEM

MONITORING THE NURSING EDUCATION SYSTEM

Previous chapters of this report have described the categories of nursing personnel required in the province, the knowledge and skills expected of these workers, and an articulated educational system designed to satisfy both the health-care needs of Albertans and the career needs of nursing personnel at all levels. The Task Force believes its proposals will do much to improve the current nursing situation in the province. At the same time, however, it recognizes that a carefully structured monitoring mechanism is required for the implementation and maintenance of such an approach to nursing education. This concluding chapter of the report is concerned with describing such a mechanism.

CURRENT MONITORING MECHANISM IN ALBERTA

Before the elements of a new structure can be appreciated, it is helpful to consider what process presently exists in the province for monitoring the educational preparation of the various levels of nursing personnel.

Nursing Aides and Nursing Orderlies Programs

Currently, the programs preparing nursing orderlies in Alberta are self monitoring. These programs are planned and offered by the Alberta Vocational Centres in Edmonton and Calgary. There is no agency legally approved to register nursing orderlies. "Registration" is obtained through the Alberta Association of Registered Nursing Orderlies.

In the case of nursing aides, programs are planned, developed and offered in Edmonton and Calgary by the Department of Social Services and Community Health, under the guidance of the Nursing Aide Advisory Council. Certified nursing aides are authorized to practise under The Nursing Aides Act.

Table 11 presents the types of provincial agencies in Canada approving nursing assistant programs in 1973. A summary of the preparation and training, general requirements, and various provincial requirements governing the education of nursing assistants, is provided in Appendix F:1.

Nurses Programs

Currently in Alberta the Universities Co-ordinating Council monitors the education of nurses. The following extract, from the *Regulations* of the Co-ordinating Council of the Universities of Alberta (1970: 3-4), describes the legal situation:

> The regulations are enacted by the Universities Co-ordinating Council of the Universities of Alberta pursuant to powers granted it by Section 11 of the Registered Nurses Act, R.S.A., 1955, Chapter 283, and amended April 7, 1966, reading as follows:
>
> The Universities Co-ordinating Council shall:
> (a) prescribe minimum standards and make regulations for schools of nursing governing such matters as, in its opinion, require to be regulated for the purpose of securing an effective educational program,
> (b) make those standards and regulations known to all interested persons, agencies, and institutions upon request,

Table 11

TYPES OF PROVINCIAL AGENCIES APPROVING PROGRAMS FOR NURSING ASSISTANTS IN CANADA, BY PROVINCE, 1973

Province	Provincial Agencies Approving Programs for Nursing Assistants					
	Provincial Nurses' Association	College of Nurses	Department of Health	Board of Registration of Nursing Assistants	Council of Practical Nurses	Board of Education
British Columbia	–	–	–	–	X	–
Alberta	–	–	X	–	–	–
Saskatchewan	X	–	–	–	–	–
Manitoba	–	–	X	–	–	–
Ontario	–	X	–	–	–	–
Quebec	–	–	–	–	–	X
New Brunswick	X	–	–	–	–	–
Nova Scotia	–	–	–	X	–	–
Prince Edward Island	–	–	X	–	–	–
Newfoundland	–	–	X	–	–	–

SOURCE: Canadian Nurses Association. *Countdown 1974*, 1975:112.

(c) provide for verification, by means of visits or otherwise, that those standards are being met and those regulations observed,

(d) approve schools of nursing which consistently meet those standards and observe those regulations,

(e) withdraw such approval from schools that do not consistently meet those standards and observe regulations, and

(f) by arrangement with the Association, conduct examinations of candidates for initial registration in the Association who either are enrolled in an approved school of nursing in the Province of Alberta or have, in the opinion of the Council of the Association, received an adequate educational program elsewhere than in the Province and are recommended by the Council to write examinations by passing which they may become eligible for registration.

To discharge the above responsibility, the Universities Co-ordinating Council appointed a Nursing Education Committee. Its current chairman is a professor of education and its members are representatives of the Alberta Association of Registered Nurses, the Alberta Medical Association, the Alberta Hospital Association, the Department of Social Services and Community Health, university schools of nursing, college-based schools of nursing, and hospital-based schools of nursing.

At the time of writing, the future of the Universities Co-ordinating Council, and therefore of the Nursing Education Committee, is uncertain. In the draft legislation of *The Adult Education Act* (Alberta. Department of Advanced Education and Manpower, 1975), the Universities

Co-ordinating Council is not specifically established, while a new body, called the Council on Professions and Occupations, is proposed. Presumably this Council, if established, would assume some of the responsibilities formerly exercised by the Universities Co-ordinating Council with respect to the governing of professional education. The Task Force has taken this draft legislation into consideration and suggests a possible amalgamation of the monitoring system described in this chapter with the proposed Council on Professions and Occupations. An explanation of this amalgamation can be found at the end of the chapter.

The draft legislation of *The Adult Education Act* also makes provision for professional associations to set academic standards through their bylaws, which are subject to approval by the Lieutenant Governor in Council, on the recommendation of the Minister of Advanced Education and Manpower. What mechanisms the Minister might employ to discharge his responsibility in this area are not certain, though the draft legislation does provide for the establishment by the Minister of *ad hoc* committees, to report to the Council concerning the nature and implications of any academic bylaw passed by a professional association. In addition, the draft legislation makes provisions for the Minister to enter into such arrangements with a professional association, as he considers desirable for the fulfillment of his functions under the Act.

What the above discussion indicates is that at the present time the issue of monitoring nursing education in Alberta is in a state of flux. As a further indicator of the variety of ways of approaching this problem, Figures 5, 6 and 7 reveal the different procedures which have been implemented in other provinces.

Figure 5 presents the various provincial authorities setting college-centered diploma nursing standards in Canada. It also indicates the nomenclature of standards and the year of the last provincial revision. Recently the Order of Nurses of Quebec has gained some authority for monitoring educational programs in nursing in that province. At the time of writing, however, details of this change have not been obtained. Figure 6 reports the various provincial authorities granting approval to diploma nursing programs in Canada. Finally, the nature of provincial nurse registration and the constituted provincial authority, which sets policies regarding licensing examinations and grants certificates, is reported in Figure 7.

Additional background information regarding diploma nursing in Canada is provided in Figure 8, which reports the number of programs in 1974 and their various institutional bases. Appendix F:2 presents a discussion of the historical development of these programs from 1964-74.

Figure 5

COLLEGE-CENTERED DIPLOMA NURSING PROGRAM STANDARD SETTING AUTHORITY, NOMENCLATURE OF STANDARDS AND YEAR OF LAST REVISION BY PROVINCE[a]

Province	Standards	Set By	Year
B. C.	Criteria	Registered Nurses Association of British Columbia	1973
Alta.	Regulations	Committee on Nursing Education, Universities Co-ordinating Council	1970
Sask.	Policies, Procedures & Criteria	Saskatchewan Registered Nurses Association Approval Committee	1973
Man.	Criteria	Manitoba Association of Registered Nurses Accrediting Committee	1974[b]
Ont.	Critical Elements (interim period 1973-1976)	College of Nurses of Ontario	1962
	Criteria	College of Nurses of Ontario	1973
	Couched in Memoranda	Council of Regents, Ministry of Colleges and Universities	1973-1974
Que.	Sciences de la Sante, Technique Biologique) Régime Pedagogique)	Direction Générale de l'Enseignement Collégial, Ministry of Education	1973

[a]Source: Information compiled from data presented in Chapters II-VIII under "Structural Organization" and "Curriculum" of this study.

[b]Criteria presently in the process of revision will be enforced in 1975.

SOURCE: Letourneau, M. *Trends in Basic Diploma Nursing Programs within the Provincial Systems of Education in Canada, 1964 to 1974.* Unpublished Ph. D. Thesis, University of Ottawa, 1975:344.

Figure 6

CONSTITUTED AUTHORITY TO GRANT APPROVAL TO DIPLOMA NURSING PROGRAMS BY PROVINCE[a]

Province	Constituted Authority
B. C.	Registered Nurses Association of British Columbia Board of Directors
Alta.	Committee on Nursing Education, Universities Co-ordinating Council
Sask.	Saskatchewan Registered Nurses Association Council Department of Continuing Education
Man.	Manitoba Association of Registered Nurses Accrediting Committee
Ont.	College of Nurses of Ontario (for a three year interim period) under the guidance of the Council of Regents, Ministry of Colleges and Universities.
Que.	Direction Générale de l' Enseignement Collégial, Ministry of Education*
	Order of Nurses of Quebec Board of Directors, by virtue of Bills 273 and 250 may participate in the elaboration of the curriculum.
N. B.	New Brunswick Association of Registered Nurses Council
N. S.	Registered Nurses Association of Nova Scotia Executive Committee
P. E. I.	Association of Nurses of Prince Edward Island subject to the approval of the Lieutenant-Governor-in-Council
Nfld.	Association of Registered Nurses of Newfoundland Council

[a]Source: Information compiled from data presented in Chapters II-VIII under "Structural Organization" and "Students" of this study.

* Apparently the Order of Nurses of Quebec now has some authority. Details are unknown at time of writing.

SOURCE: Letourneau, M. *Trends in Basic Diploma Nursing Programs within the Provincial System of Education in Canada, 1964-1974.* Unpublished Ph.D. Thesis, University of Ottawa, 1975:346.

Figure 7

NATURE OF REGISTRATION, CONSTITUTED AUTHORITY TO SET POLICIES REGARDING LICENSURE EXAMINATIONS AND TO GRANT REGISTRATION CERTIFICATES BY PROVINCE[a]

	Licensure Examinations	Registration	
Province	Set Policies	Grant Certificates	Nature
B. C.	RNABC Board of Examiners	RNABC Board of Directors	Permissive
Alta.	Board of Examiners in Nursing, Universities Co-ordinating Council	AARN Registrar	Permissive
Sask.	SRNA Board of Examiners	SRNA Council	Permissive
Man.	MARN Board of Examiners	MARN Board of Directors	Permissive
Ont.	College of Nurses Council	Director of College of Nurses	Permissive*
Que.	ONQ Boards of Examiners (French and English section)	ONQ Board of Directors	Mandatory
N. B.	NBARN Council	NBARN Council	Permissive
N. S.	RNANS Board of Examiners	RNANS Executive Committee	Permissive
P. E. I.	ANPEI Examining Board	ANPEI Council	Mandatory
Nfld.	ARNN Board of Examiners	ARNN Council	Mandatory

[a] Source: Information compiled from data presented in Chapters II-VIII under this study.

* To be accurate, should be stated as mandatory.

SOURCE: Letourneau, M. *Trends in Basic Diploma Nursing Programs within the Provincial System of Education in Canada, 1964-1974.* Unpublished Ph.D. Thesis, University of Ottawa, 1975:349.

Figure 8

TOTAL NUMBER OF HOSPITAL-ORIENTED, INDEPENDENT AND COLLEGE CENTERED DIPLOMA NURSING PROGRAMS IN CANADA IN 1974[a]

Province	Number of Programs			
	Hospital-Oriented	Independent	College-Centered	Total
B. C.	4	0	4	8
Alta.	6	0	5	11
Sask.	0	0	2	2
Man.	5	0	1	6
Ont.	0	0	23	23
Que.	0	0	42	42
N. B.	1	4	0	5
N. S.	7	0	0	7
P. E. I.	0	1	0	1
Nfld.	4	0	0	4
TOTAL	27	5	77	109

[a]Source: Information compiled from data presented in Chapters II-VIII of this study.

SOURCE: Letourneau, M. *Trends in Basic Diploma Nursing Programs within the Provincial System of Education in Canada, 1964-1974.* Unpublished Ph.D. Thesis, University of Ottawa, 1975:328.

PROPOSED SYSTEM FOR MONITORING NURSING EDUCATION IN ALBERTA

The Task Force feels that the development of an effective mechanism to monitor nursing education in Alberta is essential to ensure regular evaluation of the system as the various stages of the educational programs are implemented. It was generally agreed that a National Accreditation Board should be created to influence standards for nursing programs across Canada. However, this board would not, in itself, set and control standards provincially; therefore the Task Force recommends the establishment of a provincial monitoring system to perform these tasks.

The monitoring system proposed by the Task Force includes both the professional and para-professional levels of nursing. In making this proposal the Task Force considered the advantages of two separate monitoring-bodies, one for each level of nursing (professional and para-professional), versus the merits of a single monitoring-body to include both. Concerned that any separation would result in a lack of coordination and communication, the Task Force proposes that a single monitoring system be established, comprised of the following components:

1. The Provincial Council on Nursing Education (subsequently referred to as the Provincial Council);

2. The Alberta Association of Registered Nurses Education Board (subsequently referred to as the Nurses Education Board);

3. The Registered Nursing Assistants Association Education Board (subsequently referred to as the Nursing Assistants Education Board).

The Provincial Council would be established by legislative authority and would report to the Minister of Advanced Education and Manpower on matters relating to education in the field of nursing. It would receive from the Nurses Education Board and the Nursing Assistants Education Board recommendations for monitoring and setting standards in nursing education. The Council would make decisions on these recommendations and advise the Minister accordingly. This type of monitoring system allows for boards solely concerned with their respective areas of nursing education to assume major (but not total) responsibility for monitoring and setting standards. At the same time it assures close coordination between professional and para-professional nursing. Figure 9 shows the relationship between the boards, council, associations and the Minister of Advanced Education and Manpower.

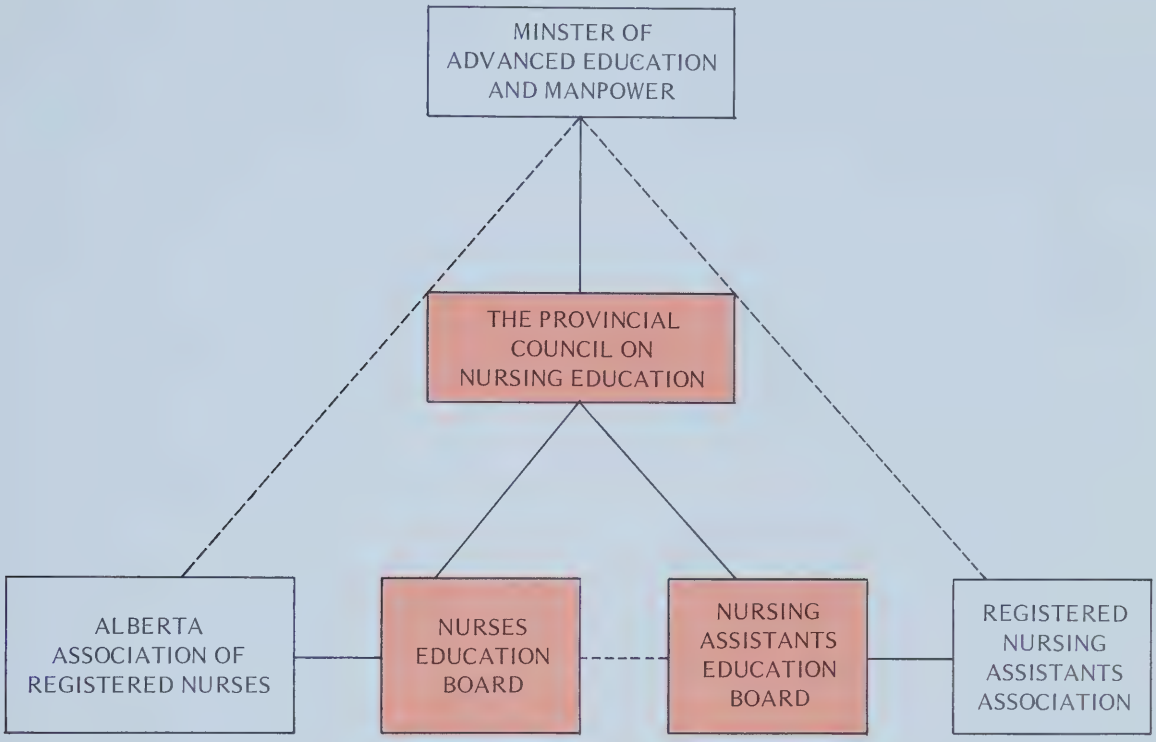
Concerning the composition of the Provincial Council, the Task Force agreed it should include one representative named by each of the following bodies:

The Department of Social Services and Community Health
The Department of Hospitals and Medical Care
The Department of Advanced Education and Manpower
The Alberta Association of Registered Nurses
The Registered Nursing Assistants Association[1]

[1]As this association does not exist at present, the Task Force by naming it as a constituent member of the Provincial Council is implicitly recommending its creation.

Figure 9

PROPOSED STRUCTURE FOR MONITORING NURSING EDUCATION IN ALBERTA


MINSTER OF ADVANCED EDUCATION AND MANPOWER
THE PROVINCIAL COUNCIL ON NURSING EDUCATION
ALBERTA ASSOCIATION OF REGISTERED NURSES
NURSES EDUCATION BOARD
NURSING ASSISTANTS EDUCATION BOARD
REGISTERED NURSING ASSISTANTS ASSOCIATION

The Alberta Medical Association
The Alberta Hospital Association
The Consumers Association of Canada
The Chairman of the Nurses Education Board, *ex officio*
The Chairman of the Nursing Assistants Education Board, *ex officio*

Thus, the Provincial Council would have the following constituencies represented on it: (a) government, (b) professional nurses, (c) nursing assistants, (d) educators, (e) other health workers and employers, (f) consumers, and (g) the chairpersons of the Nurses Education Board and the Nursing Assistants Education Board as *ex officio* members.

The Chairman of the Council would be appointed by the members. The Task Force also feels the Council should meet no less often than twice a year to maintain communication with the two boards.

The Nurses Education Board would be established by the Alberta Association of Registered Nurses, under the authority of its professional Act. The Board would be responsible for recommending to the Provincial Council both standards in professional nursing education and procedures to monitor them. The procedures would then be implemented through the Board under the aegis of the Council.

The Nursing Assistants Education Board would be established in the same way under its association, and would have similar responsibility for recommending the setting and monitoring of standards for nursing assistants' training programs.

The functions of the two boards would be determined by their respective parent bodies, not the Council. However, they would be advisory to the Council which in turn would coordinate their activities. Further coordination would be achieved through direct contact between the boards, for example, by shared membership.

Concerning membership, the Task Force did not determine the specific compositon of each education board but recommends the inclusion of representation from the related associations and professions. However, majority representation on each board should be from the respective association.

The Task Force believes that the details of the monitoring system should be developed by the Provincial Council on the recommendation of the education boards. However, it wishes to stress that the mechanism must address itself to system-wide matters as identified in the previous chapters of this report. Some of the functions would include:

1. The articulation of non-university and university programs and their relationship with health-care facilities;

2. The approval of nursing education programs which consistently meet standards and regulations, and the withdrawal of approval when deemed necessary;

3. The provision of consultation services to strengthen the quality of nursing education programs;

4. The examination of trends in nursing and nursing education on a national and provincial level;

5. The support of research with respect to:
   (a) the turnover and attrition rates of all nursing students,
   (b) follow-up studies of graduates,
   (c) instructional methods;

6. The promotion of effective regional or local agreements among the various programs and agencies for cooperative and effective utilization of suitable clinical facilities, curriculum materials (including use of available media), and teaching facilities;

7. Liaison with government and non-government agencies concerned with manpower needs in the area of nursing and related health personnel. This would take into consideration such factors as manpower supply, demand, utilization, and cost;

8. The development of any additional programs, (including those in clinical specialty areas) in terms of present and future manpower needs, and the quality and availability of necessary resources;

9. The arrangements for writing the examinations of the Canadian Nurses Association Testing Services.

PROPOSED COUNCIL ON PROFESSIONS AND OCCUPATIONS

The preceding section has outlined the Task Force's proposal for establishing a means of monitoring nursing education in Alberta. As referred to earlier in this chapter, the draft legislation of *The Adult Education Act* also addresses this issue, but in the broader context of all professions and occupations. In the event that a Council of Professions and Occupations, as described in the Act, is established, the Task Force believes that the proposed structure for monitoring nursing education could be incorporated with the Council by the mechanism depicted in Figure 10.

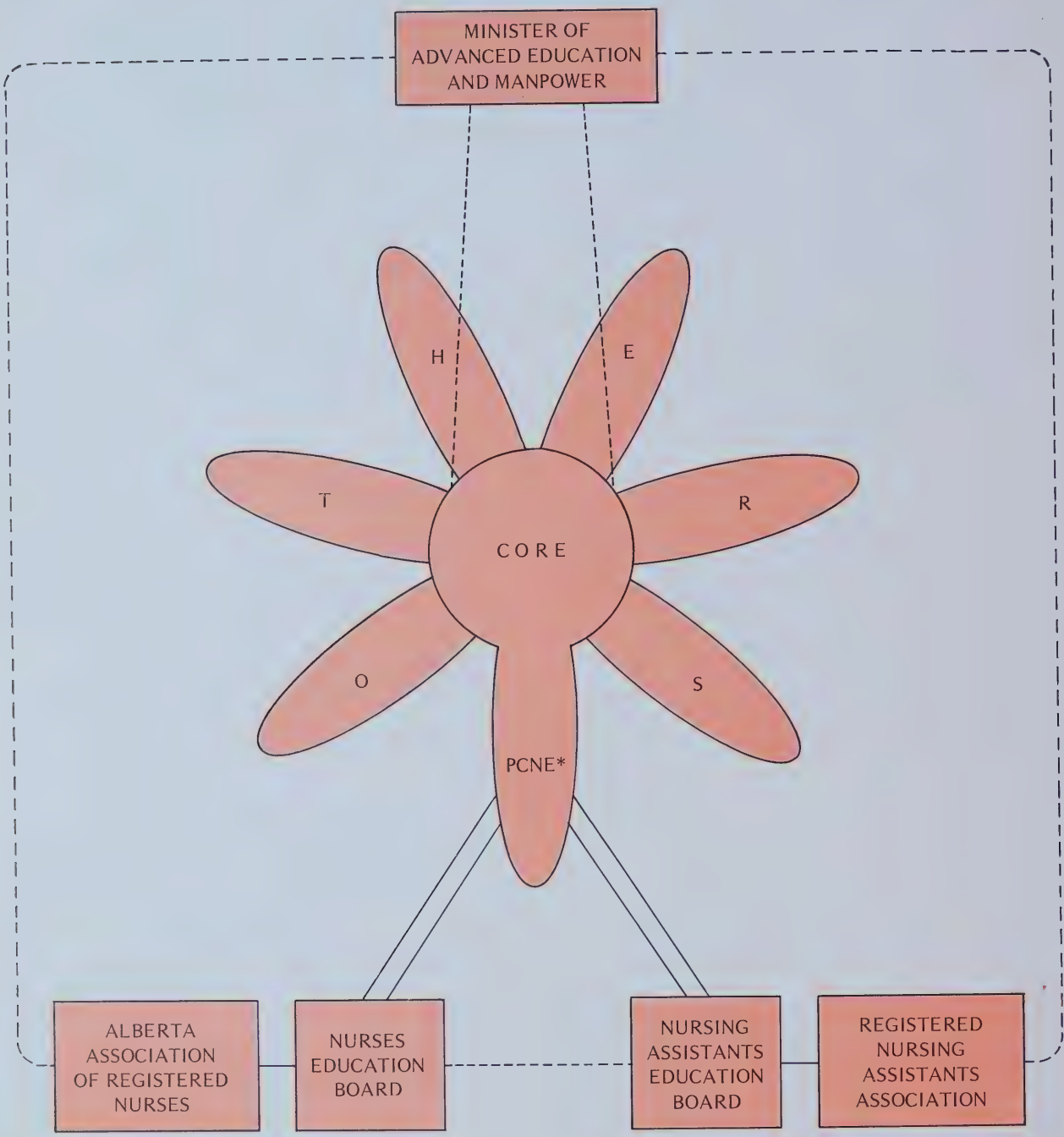
As shown, the Council of Professions and Occupations would consist of a core of full-time members, supplemented by additional members who will vary according to the particular professional or occupational group under consideration. The core would be small, probably no more than three people drawn from the system of advanced education and the public. The principle underlying this proposal is that the Council on Professions and Occupations would take a different configuration depending on which professional or occupational group it is concerned with at the time.

With respect to the nursing field, the Council, as shown in Figure 10, would consist of its core plus the Provincial Council on Nursing Education. The implication of this arrangement is that the latter Council would be expanded when dealing with issues of academic standards, but would revert to its original membership when carrying out its other specified functions.

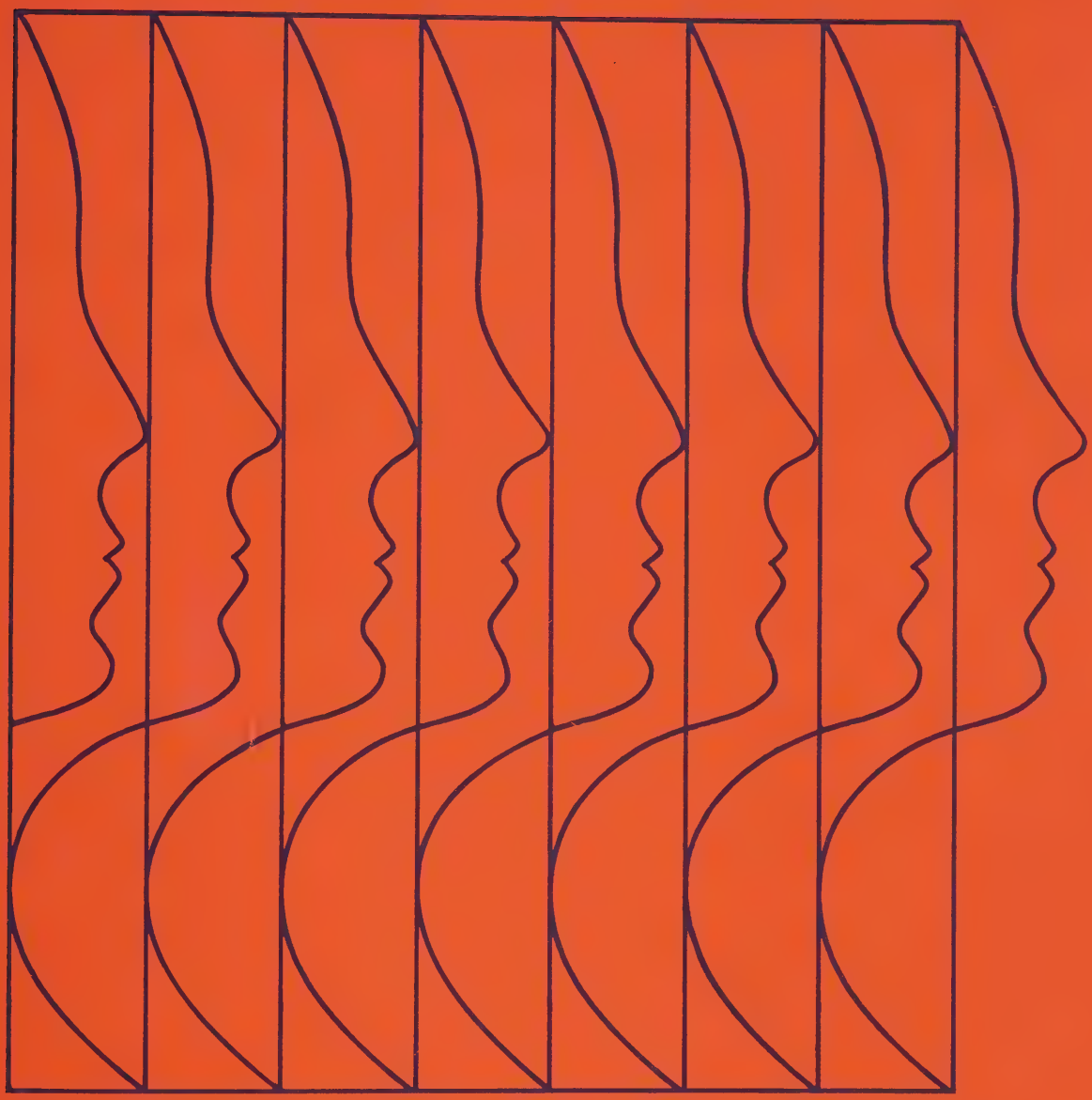
Whatever is eventually decided concerning the proposed Council on Professions and Occupations, there can be no doubt that the establishment of an effective mechanism to monitor nursing education is crucial. The Task Force is confident that the proposal outlined in this chapter will accomplish this important task, and thereby provide to nursing education the capability it requires to develop and respond realistically to the complex demands of the health-care delivery system.

Figure 10

PROPOSED AMALGAMATION BETWEEN THE MONITORING SYSTEM FOR NURSING EDUCATION AND THE COUNCIL ON PROFESSIONS AND OCCUPATIONS



*Provincial Council on Nursing Education



RECOMMENDATIONS

RECOMMENDATIONS

Throughout the course of its deliberations the Task Force developed a number of positions with regard to nursing education and the health care delivery system within which nursing personnel serve in Alberta. These positions have been elaborated in the various chapters of the Report in accordance with the approach which the Task Force took in organizing its work.

In this section of the Report specific recommendations drawn from the body of the text are enumerated, which, if implemented, will serve to move nursing education and service in the direction which the Task Force believes they should take.

These recommendations are organized in two main sections: those that pertain to nursing education are presented first and those that relate to the health-care delivery system follow. Because the Task Force was charged specifically with examining educational issues, the majority of recommendations fall in the former category, though this should not be interpreted to mean that those relating to health-care delivery are in any way less important.

I. NURSING EDUCATION

Credit Programs

1. STRUCTURE

(a) Program Development

1. That all nursing education be established as a component of the advanced education system.

Ch. 6: 73, 74

2. That there be two distinct and separate levels in the nursing education system in Alberta: one for the preparation of professional personnel, the other for the preparation of para-professional personnel.

Ch. 3: 27, 28; Ch. 6: 73

3. That professional nursing education be planned so that non-university programs articulate with university-based programs in accordance with the principle of a continuum of nursing education.

Ch. 6: 79, 82, 83

4. That until 1985 the professional level of the system prepare nursing personnel on a continuum from Grade XII matriculation, or an acceptable alternative, through the diploma program articulated with a university nursing program, the baccalaureate program, and the customary advanced degree levels — Master's and Doctoral — and beyond.

Ch. 6: 73, 77, 85

5. That by 1985 there be two routes to professional nursing preparation: (1) a university-based baccalaureate program, and (2) an articulated baccalaureate program between a non-university setting and a university setting.

Ch. 6: 76, 82, 83

6. That by 1990 the minimum educational preparation for professional nursing be the baccalaureate, whatever route to the degree is chosen.

Ch. 3: 32, 33, 34; Ch. 4: 43, 45; Ch. 5: 50, 51, 52;
Ch. 6: 73, 75, 76, 95

7. That appropriate arrangements be made relative to the requirements specified in Recommendations (5) and (6) for annual registration of those nurses who will have registered prior to 1990 within the provisions and by-laws of the Registered Nurses Act.

Ch. 6: 83

8. That to accomplish Recommendations (3), (4), (5) and (6) planning by the universities and non-university institutions begin immediately.

Ch. 6: 79, 88, 95

9. That the length of the non-university nursing program adhere to the current Regulations Governing Schools of Nursing in the Province of Alberta *viz.* that the minimum length of the program shall be 22 months exclusive of vacation. More specifically, the Task Force recommends the minimum length of program be 96 weeks exclusive of vacation.

Ch. 5: 58; Ch. 6: 77

10. That a modular instructional package in a clinical nursing area be clearly delineated in non-university programs as soon as possible so that by 1980 all graduates of these programs will be required to have taken this module prior to writing registered nurse examinations. Examples of possible areas of focus are contained in Recommendation (42).

Ch. 6: 77, 87, 88

11. That within the 96 weeks of the non-university program there be a five week evaluated work-study experience related to patient care management and leadership skills. This experience would be subsequent to the module on Clinical Nursing so that the principles of patient care management would be applied to an area of focus or concentrated study.

Ch. 4: 41; Ch. 6: 77

12. That non-university programs whose length exceeds the minimum 96 weeks be re-designed to incorporate the modules identified in Recommendation (13).

Ch. 6: 77

13. That commencing with students who will graduate in 1980 approval be granted to write the registered nurse examinations in accordance with the following schedule (which should be shortened if possible):

Clinical Nursing module to be required by 1980
An additional module in Community Health Nursing to be required by 1985
An additional module in the Instructional Process to be required by 1990
An additional module in Primary Care in Health Services to be required by 1990.

Ch. 2: 23; Ch. 6: 82

14. That the three additional thirteen week modules referred to in Recommendation (13) be planned in such a way that the eligible candidates can take each one of them as time, financial ability and other factors permit.

Ch. 6: 79

15. That there be joint planning and development of all modules by nursing education and nursing service representatives from non-university and university institutions.

Ch. 6: 87, 88, 95

16. That appropriate arrangements in accordance with the schedule referred to in Recommendation (13) be made to enable graduates from outside Alberta to achieve Alberta nurse registration.

Ch. 6: 83

17. That the faculty of nursing of the University of Calgary institute in the very near future, a baccalaureate program for diploma nurses.

Ch. 5: 66

18. That the faculties of nursing of the University of Alberta and the University of Calgary develop in the very near future, Master's degree programs for the preparation of teachers of nursing, clinical nursing specialists and administrators of nursing services.

Ch. 4: 46; Ch. 5: 50, 51; Ch. 6: 85, 86

19. That special funds be made available to faculties of nursing in the universities to appoint nurse faculty members holding Doctoral degrees to develop at the Master's level, programs to prepare clinical nursing specialists, teachers of nursing and administrators of nursing services.

Ch. 4: 37, 45, 46; Ch. 5: 49, 50, 51; Ch. 6: 85, 86

20. That special funds be provided for upgrading the qualifications of present and future instructors in the non-university schools of nursing.

Ch. 6: 85, 86

21. That prospective candidates for a Doctoral degree in nursing be encouraged to pursue this program through the provision of grants or bursaries and, to this end, that for a minimum of five years beginning immediately, at least three Doctoral candidates in nursing be assisted each year to pursue studies in clinical nursing, nursing education, nursing research and nursing administration. Such assistance should contain a "return to province" requirement.

Ch. 5: 49, 50; Ch. 6: 85, 86

22. That the educational system for para-professionals be modified to prepare the category of the Registered Nursing Assistant, whose training is achieved by the amalgamation of the present Certified Nursing Aide and Nursing Orderly programs.

Ch. 4: 38, 39 ; Ch. 6: 74

23. That the minimum entrance requirement into the Registered Nursing Assistant program be Grade X or an acceptable alternative.

Ch. 6: 74

24. That the principle of registration for practice for the graduates of the program referred to in Recommendation (22) be endorsed.

Ch. 6: 74

25. That there be established an Alberta Registered Nursing Assistants Association.

Ch. 6: 74; Ch. 7: 106

26. That the legislature of Alberta enact a statute to be known as the Registered Nursing Assistants Act, which shall supersede the existing Nursing Aides Act.

Ch. 6: 74

27. That personal care aides, whom the Task Force considers to be health care personnel rather than nursing personnel, be prepared outside the advanced education system.

Ch. 4: 37, 38

28. That personal care aides be trained for their specific job by the agency in which they function, or through contractual arrangements between their employing agency and an educational institution, or by some combination of these approaches so that the training is structured, planned, and carried out by adequately prepared individuals. No formal certificate or diploma should be issued to this level of worker.

Ch. 4: 37, 38

(b) Articulation

29. That the Provincial Council on Admissions and Transfer consider as a priority the resolution of transfer issues in the area of nursing education within the framework of these recommendations.

Ch. 6: 83

30. That articulation among educational institutions be instituted by:

(i) preparation of well-defined curricula outlines for each course spelled out in terms of measurable objectives that can be used as a base for transfer agreements;
(ii) use of proficiency/equivalency testing programs when applicable.

Ch. 6: 83

31. That provision be made for individuals to transfer from one nursing "career ladder" to the other, with emphasis placed on career counselling so that prospective nursing personnel initially select the "career ladder" appropriate to their motivation and ability.

Ch. 6: 74

32. That opportunities for transfer to professional nursing programs be available to Registered Nursing Assistants by the process of challenge examinations and the evaluation of clinical performance, when basic academic admission standards have been met.

Ch. 6: 74

33. That articulation procedures through the identification of common elements be worked out between the advanced education institutions involved to facilitate the transfer of nursing students into other health related occupations or the transfer of students from such occupations into nursing.

Ch. 6: 83

2. CURRICULUM

(a) Professional

34. That the general education component of the curriculum include a strong base related to the biological, behavioural and bio-social sciences.

Ch. 2: 9, 10; Ch. 3: 33, 34; Ch. 4: 39, 40, 41, 42, 43, 45;
Ch. 6: 76, 77, 84

35. That the nursing component of the curriculum demonstrate didactic and clinical applications of the biological, behavioural, bio-social and medical sciences.

Ch. 4: 39, 40, 41, 42, 43, 44, 45;
Ch. 6: 77, 79, 83, 84

36. That the curriculum provide opportunities to examine the similarities and differences within the various health care delivery models and practices therein.

Ch. 2: 16, 17, 18, 21, 22, 24; Ch. 3: 27; Ch. 6: 83, 84, 85

37. That the nursing curriculum provide opportunities for the development of a value system within which decisions can be made.

Ch. 4: 45; Ch. 6: 76, 83, 84

38. That the curriculum emphasize the need for nurses to know how to collect data and formulate hypotheses related to the prevention and cause of illnesses of internal and external origin and the effects of nursing intervention, thus contributing to health research.

Ch. 6: 83, 84

39. That the curriculum emphasize therapeutic counselling skills to prepare practitioners to be more effective in motivating individuals, families, and communities to make informed decisions regarding such matters as diet, rest and exercise, smoking, drinking, the use of drugs, and family planning.

Ch. 2: 11, 12, 13, 14; Ch. 6: 83, 84

40. That the curriculum emphasize teaching-learning principles and the application thereof to prepare practitioners to become more effective partners in health and family life education.

Ch. 2: 13, 14, 16; Ch. 4: 43, 44, 45;
Ch. 6: 76, 77, 79, 83, 84

41. That the curriculum emphasize the study of trends in the evolving role of nursing.

Ch. 6: 79, 83, 84

42. That the curriculum provide opportunities for clinical electives, concentrated study, and independent study in a particular area of focus such as medical-surgical; paediatric nursing; advanced practical obstetrics; geriatric nursing; extended care; and psychiatric nursing.

Ch. 6: 77, 83, 84

43. That priorities for courses and programs in the above areas of focus be established jointly by the appropriate organization, educational institutions, health care agencies, and government.

Ch. 6: 77, 95; Ch. 7: 108

44. That the curriculum recognize that a solid grounding in the knowledge and skills relating to mental health and social concerns is essential to nursing practice.

Ch. 6: 79, 83, 84

45. That proposals designed to meet the present acute shortage of nurses in the mental health field, be actively considered for implementation. When deemed advisable these proposals should be structured so as to incorporate credit toward a baccalaureate degree.

Ch. 5: 65, 66

(b) Para-professional

46. That the future para-professional program be developed to reflect the present level of the Certified Nursing Aide and Nursing Orderly programs.

Ch. 4: 38; Ch. 6: 74

47. That the curriculum foci be on patient self-care deficits related to activities of daily living, comfort measures, patient safety and on procedural skills defined as being within the area of para-professional nursing practice.

Ch. 4: 38; Ch. 6: 74

48. That no more than fifty per cent of the practicum of the Registered Nursing Assistant program be given in urban active treatment centres.

Ch. 6: 75

49. That there be opportunities following completion of the basic program for Registered Nursing Assistants, to develop additional skills in such areas as the operating room, mental health, emergency services, obstetrics, urology and orthopaedics.

Ch. 4: 38, 39; Ch. 6: 74, 75

(c) Clinical Resources

50. That collaboration between the nursing education and nursing service sectors be established by recognizing that the preparation of nursing personnel is a joint endeavour.

Ch. 6: 88, 89, 90, 93, 94, 95

51. That there be increased access for nursing students to primary care facilities in the urban and rural areas through:

(i) full utilization of available local educational and health care facilities in urban centres and rural areas;
(ii) full utilization of available local human resources: physicians, dentists, nurses and allied health workers, as well as personnel associated with local facets of federal, provincial and municipal health care programs.

Ch. 2: 21, 22; Ch. 6: 91, 92

52. That there be effective regional or local arrangements among the various nursing programs and health-care agencies for cooperative utilizations of suitable clinical resources taking into consideration established priorities for nursing education development.

Ch. 6: 74, 89, 90, 91; Ch. 7: 108

53. That the incremental cost of integrating nursing education and service programs (including the cost of release time for supervision) be recognized and subsidized by the government.

Ch. 6: 91

54. That clinical opportunities provide creative learning experience through the improvement, diversification, and more effective use of:

(i) hospitals;
(ii) outpatient and ambulatory care clinics;
(iii) emergency medical care;
(iv) family care centres;
(v) nursing homes and extended care facilities;
(vi) community health care centres;
(vii) hospital outreach programs and community outreach centres for drug abuse, venereal disease, alcoholism, anti-smoking, family planning and others;
(viii) home settings;
(ix) industrial and commercial settings;
(x) schools.

Ch. 2: 14, 20, 21, 22, 24; Ch. 6: 76, 77, 79, 87, 88, 91, 92

(d) Faculty

55. That the Master's level become the minimum educational preparation for nurse educators; this is to be accomplished as soon as possible.

Ch. 5: 52

56. That instructors of nursing normally be involved in the practice of nursing in the appropriate clinical setting to ensure continued competence in practice.

Ch. 6: 88, 89, 95

57. That the integration of nursing service and nursing education be facilitated through shared appointments, clinical appointments or associate appointments between educational institutions and health care facilities.

Ch. 6: 88, 89, 93, 95

Non Credit Programs

1. MAINTAINING NURSING MANPOWER QUALITY

(a) Orientation

58. That all health agencies provide sound orientation programs to new staff members to acquaint them with the agencies' functions and their responsibilities within it.

Ch. 5: 69; Ch. 6: 93

(b) In-Service Education

59. That health agencies recognize their responsibility to provide in-service programs to their nursing employees thus ensuring maintenance of nursing manpower competence.

Ch. 6: 92, 93

60. That recognition be given to the fact that the new nursing graduate's application of skills in management and leadership requires in-service educational programs, and that such programs, appropriate to the individual's and the employment situation, be available.

Ch. 4: 41; Ch. 6: 77

(c) Refresher

61. That refresher and retraining courses for nursing personnel be developed to:

(i) upgrade knowledge base related to the basic sciences;
(ii) upgrade communication and technical skills.

Ch. 5: 67; Ch. 6: 93

2. CONTINUING EDUCATION

62. That professional organizations and educational institutions continue to provide professional growth opportunities through conventions, workshops, lecture series, etc.

Ch. 2: 17, 18; Ch. 6: 93, 94, 95

63. That participation in continuing education programs be encouraged through the development of various incentives such as educational leave, or travel assistance, etc.

Ch. 6: 94

64. That when deemed advisable financial assistance programs be developed through liaison with service agencies, educational institutions, and government to enable registered nurses to upgrade their education to the baccalaureate.

Ch. 6: 93, 94

Monitoring

1. STRUCTURE

65. That monitoring and coordination mechanisms in relation to professional and para-professional nursing education be implemented by the creation of the following bodies:

(i) The Provincial Council on Nursing Education;
(ii) The Alberta Association of Registered Nurses Education Board (subsequently referred to as the Nurses Education Board);
(iii) The Registered Nursing Assistants Association Education Board (subsequently referred to as the Nursing Assistants Education Board).

Ch. 7: 106

66. That the Provincial Council on Nursing Education be established by legislative authority and report to the Minister of Advanced Education and Manpower on matters relating to education in the field of nursing. The Council would receive from the Nurses Education Board and the Nursing Assistants Education Board recommendations for monitoring and setting standards in nursing education. It would make decisions on these recommendations and advise the Minister accordingly.

Ch. 7: 106

67. That the Provincial Council on Nursing Education include one representative named by the respective bodies as follows:

The Department of Social Services and Community Health
The Department of Hospitals and Medical Care
The Department of Advanced Education and Manpower
The Alberta Association of Registered Nurses
The Alberta Registered Nursing Assistants Association
The Alberta Medical Association
The Alberta Hospital Association
The Consumers Association of Canada
The Chairman of the Nurses Education Board, *ex officio*
The Chairman of the Nursing Assistants Education Board, *ex officio.*

Ch. 7: 106, 107

68. That the Chairman of the Provincial Council on Nursing Education be named by the membership on the Council.

Ch. 7: 107

69. That the Council meet no less often than twice a year.

Ch. 7: 107

70. That, if a Council on Professions and Occupations is established, the Provincial Council on Nursing Education be incorporated with the Council on Professions and Occupations insofar as academic standards are concerned, but remain separate for the purpose of carrying out its other specified functions.

Ch. 7: 109, 110

71. That the Nurses Education Board be established by the Alberta Association of Registered Nurses, under the authority of its professional Act. The Board shall be advisory to the Provincial Council on Nursing Education, and would be responsible for recommending to the Council both standards in professional nursing education and procedures to monitor them. The procedures would then be implemented through the Board under the aegis of the Council.

Ch. 7: 107

72. That the Nursing Assistants Education Board be established by the proposed Alberta Registered Nursing Assistants Association under the authority of the proposed Registered Nursing Assistants Act. The Board shall be advisory to the Provincial Council on Nursing Education, and would be responsible for recommending to the council both standards in para-professional nursing education and procedures to monitor them. The procedures would then be implemented through the Board under the aegis of the Council.

Ch. 7: 108

73. That the composition of each education board include representation from the related associations and professions, but that in each case there be a majority representation from the respective association.

Ch. 7: 108

2. FUNCTION

74. That the monitoring bodies concern themselves with system-wide matters including the following:

(i) the articulation of the nursing education system;
(ii) the regulations and procedures governing the operations of professional and para-professional nursing education programs in terms of:
  — general organization and administration
  — philosophy and objectives
  — faculty
  — admission and promotion of students
  — student policies
  — curriculum development
  — educational resources and facilities;
(iii) the approval of nursing education programs which consistently meet standards and regulations;
(iv) the provision of consultation services;
(v) the examination of trends in nursing and nursing education on a national and provincial level;
(vi) the support of research with respect to:
  — turnover and attrition rates of all nursing students
  — follow-up studies of graduates
  — instructional systems;
(vii) the promotion of effective regional or local arrangements for cooperative utilization of clinical resources, curriculum materials, and teaching facilities;

(viii) liaison with government and non-government agencies concerned with manpower needs in the area of nursing and related health personnel;
(ix) the arrangements for writing the examinations of the Canadian Nurses Association Testing Service; and the
(x) development of any additional programs.

Ch. 6: 74, 86, 87, 95; Ch. 7: 108, 109

II. HEALTH CARE DELIVERY SYSTEM

Health Promotion and Maintenance

75. That the future mode of delivering services be restructured to establish a more equitable emphasis between the medical care model and the health care model by various methods including the following:

(i) increased emphasis on health promotion, health maintenance, risk group identification, disease prevention, early diagnosis, prompt treatment, disability limitation and rehabilitation;
(ii) more, better and easier access to both episodic and distributive intervention services;
(iii) continued research into the cause and prevention of environmental, genetic, biological, mental or behavioural and social health problems;
(iv) increased counselling, coordination and continuity of care for families;
(v) increased fiscal and manpower resources to provide more adequate health promotion, health maintenance and disease prevention and rehabilitative services:
— to all age groups in the population
— to population groups with special health problems;
(vi) increased application of the ways and means social institutions (such as trade unions, industry and commerce, government, schools, religious organizations, family and recreational organizations) can contribute to health promotion and maintenance and illness prevention;
(vii) increased upgrading and vigilance of standards related to the physical environment (housing, air & water, waste disposal, etc.).

Ch. 1: 5; Ch. 2: 11, 12, 14, 16, 17, 18, 20, 21, 22, 23; Ch. 3: 32, 33; Ch. 6: 84, 85

Organizational Issues

76. That the future mode of delivering services place increased emphasis on comprehensive care and attempt to minimize fragmentation, and duplication by various strategies including the following:

(i) improved services to all population groups with special emphasis on the elderly, the isolated, those being transferred from general and psychiatric hospitals to various community and institutional settings, and those in extended care facilities;
(ii) increased integration of "health" and "mental health" services;
(iii) increased communication, coordination and collaboration between the health service and the educational system;
(iv) greater emphasis on primary health care facilities and functions;
(v) increased communication, collaboration and coordination among health-related disciplines responsible for the delivery of health services.

Ch. 2: 9, 10, 16, 21, 22, 23, 24; Ch. 3: 32, 33; Ch. 4: 43; Ch. 6: 88, 95

Health Education

77. That in the future mode of delivering services consumer health education strategies be developed to raise the individual's awareness of his responsibility to make informed decisions regarding his own health status. Such strategies would include the following:

(i) the fostering of caring relationships;
(ii) community college courses designed to help individuals relieve the strains of life and living caused by factors such as:
— water and air pollutants
— urban crowding
— traffic congestion
— noise
— economic instability
— general societal unrest
— stress;
(iii) courses, special lectures, and programs presented in various community locations and designed to provide health information to change personal attitudes and behaviour with regard to:
— nutrition
— family planning
— smoking

— alcohol
— drug abuse
— venereal disease
— heart disease
— cancer
— stroke
— mental health and mental illness
— patterns of usage of health services;

(iv) programs for orientation to the overall health care system: its components, locations, avenues of entry, and use;

(v) development and expansion of health and family life education in all educational institutions by greater utilization of appropriately trained personnel, such as day care workers, teachers, employers and health service workers.

Ch. 2: 10, 12, 13, 14, 15, 16, 17, 21, 22, 24; Ch. 3: 32

Health Manpower Utilization

78. That the future mode of delivering services place an increased emphasis on more effective manpower utilization by evaluating key issues including the following:

(i) the proliferation and overlap of various categories of health care personnel and the establishment of appropriate numerical limits on these categories;

(ii) the defining of limits of responsibility for various nursing personnel in accordance with legal and remunerative implications;

(iii) the assessment of the ratio of registered nurses to registered nursing assistants needed in any health care institution in accordance with a classification of patient care needs and a reliable work load index established and tested in the institution, rather than by arbitrary staff-patient or staff-bed ratios;

(iv) the implementation of an interdisciplinary approach in nursing service;

(v) the turnover and attrition rates of nursing personnel;

(vi) support for research by nurses into areas which have relevance for improvement of nursing practice and the delivery of nursing services.

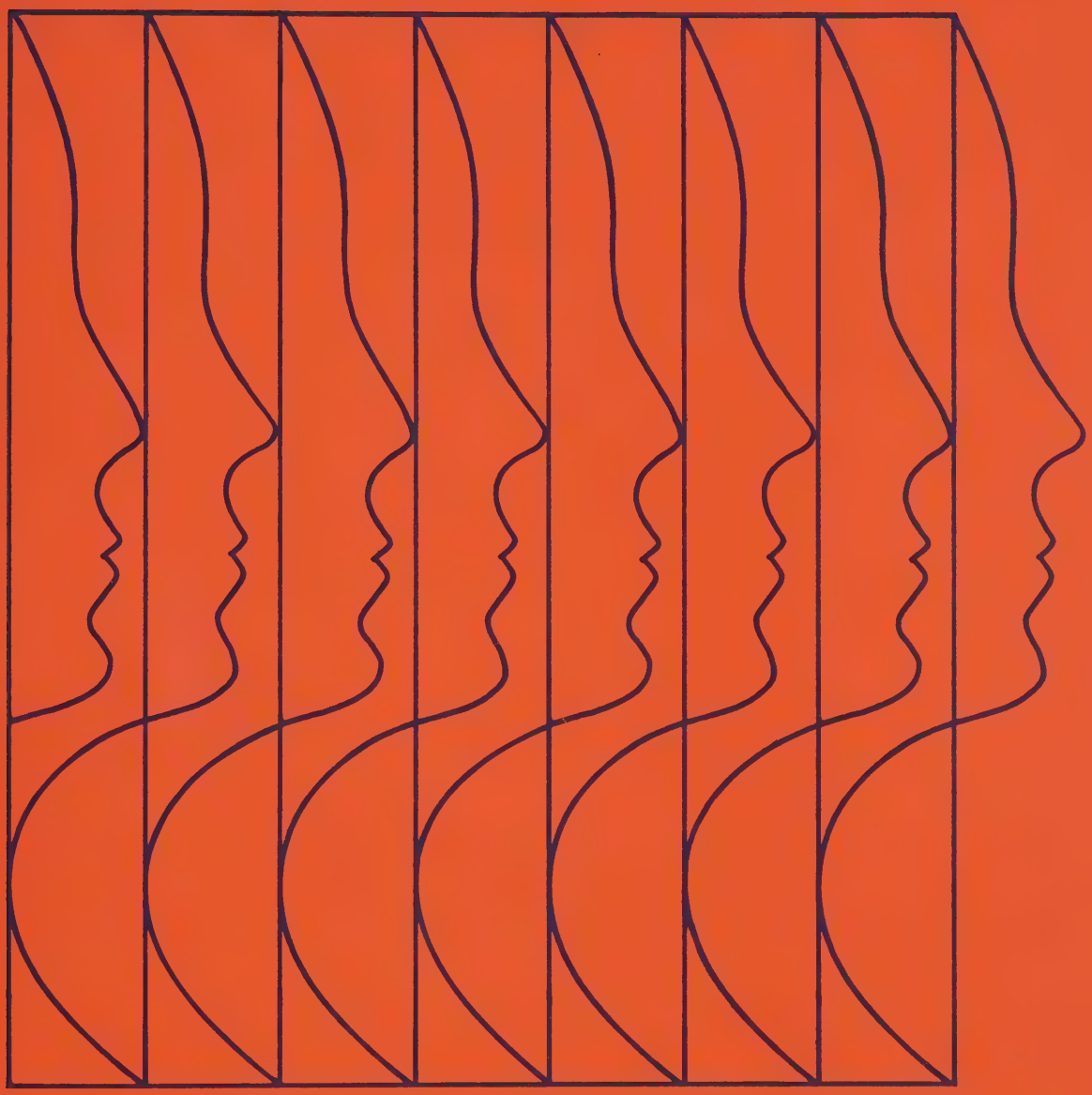
Ch. 2: 14, 21, 23; Ch. 3: 29, 30, 31, 32, 33; Ch. 4: 43; Ch. 5: 49, 50, 66, 67; Ch. 6: 74, 84, 85

79. That employing agencies in Alberta recognize their responsibility to employ as nurses only *bona fide* registered nurses.

Ch. 4: 43, 45; Ch. 5: 49, 50, 51; Ch. 6: 82, 83, 90

80. That employing agencies in Alberta recognize that quality nursing service can be delivered only by professional and para-professional personnel as defined in this report.

Ch. 5: 49, 50, 51; Ch. 6: 73, 75, 76, 90



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WHAT THE NURSE NEEDS TO KNOW, UNDERSTAND AND BE ABLE TO DO TO FUNCTION EFFECTIVELY IN COMMUNITY (INCLUDING OCCUPATIONAL) HEALTH SERVICES

Health Supervision of the Individual

Understanding and/or knowledge of:

Principles and practices of health assessment;
Principles and practices of health screening;
Use and normal values of biological tests;
Principles and practices of laboratory procedures for health assessment;
Psychology of motivation and of human behaviour;
Principles and methods of social work, including knowledge of the means for liaison with agencies both in the organization and the community;
Basic principles of interviewing and counselling;
Principles and practices of ergonomics and job analyses;
Stress;
Aging;
Communicable and chronic diseases;
Principles and practices of rehabilitation;
Relevance of the helping relationship to an effective service

are suggested as content if the nurse is to learn how to:

Carry out a health interview;
Relate the findings of the health interview to the work situation;
Assess the individual's physical and mental health;
Evaluate the limitations and assets of handicapped employees;
Help the employee define his own health needs and goals and deal constructively with them;
Develop accurate information about the employee's overt and covert health problems;
Counsel workers with physical and mental health problems;
Help workers accept referrals to social agencies, mental health centres, and other treatment centres;
Apply control measures, on-the-job that will minimize sick-absence and work curtailments in the event of community epidemics;
Co-ordinate communicable disease control measures, including reporting to government control program;
Understand the psychological and social aspects as well as the physiological course of certain diseases (e.g. venereal disease) as they affect occupational productivity among employees;
Identify health maintenance needs of employee and family;
Assist with and/or perform:

a. pre-placement examinations,
b. periodic examinations of workers exposed to specific hazards in their work,
c. examination of employees at the termination of employment,
d. examination of employee with individual health problems, i.e. exposure to asbestos, radiation, beryllium;

Develop a vision conservation programme;
Conduct tests of vision, hearing, and pulmonary function;
Develop a hearing conservation programme;
Supervise technicians conducting screening tests;
Set up occupational disease surveillance programme;
Set up a follow-up programme for workers with health problems;
Keep workers with health problems under regular surveillance;
Assist with laboratory tests;
Interpret individual health status to the persons who have a right and responsibility to know, especially as these relate to job placement and rehabilitation;
Plan and conduct an immunization programme;
Co-ordinate the health supervision of employees who are being rehabilitated following illness or injury;
Teach people who are not patients to maintain

their own health;
Teach workers to identify potential and specific health hazards and to recognize their own health problems;
Assess health habits of employees;
Assess eating habits and related nutritional status of employees;
Participate with other personnel in a co-operative programme in the control of communicable disease;
Use modern statistical methods in health surveillance (e.g. automatic data processing);
State community's responsibility for the protection of the health of its people;
List the community's resources and institutions that deal with the health care needs of the people;
Participate in placement of individuals in jobs compatible with their health status and the requirements of jobs of the organization;
Apply scientific observation and objective judgment evaluating a person's degree of wellness.

SOURCE: Smith, D.L. "The Preventive Aspects of Occupational Health Nursing and Implications for Training." Paper for Certificate in Occupational Health Nursing, Royal College of Nursing, London, England. (Mimeographed), 1975:107-108.

EXCERPTS FROM THE REPORT OF THE INDUSTRIAL HEALTH AND SAFETY COMMISSION, ALBERTA, 1975

In 1950 the Joint ILO/WHO Committee defined occupational health. This definition still stands:

> "Occupational health should aim at: the promotion and maintenance of physical, mental and social well being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in the employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological equipment, and to summarize: the adaption of work to man and of each man to his job."

In exploring the problems pertaining to occupational health services, [the] Commission has felt that the focus should be the worker and his work site. Bearing in mind the aims of occupational health, we have identified in general terms the needs of the worker. They are:

(1) That the work site and his work practices are not a health hazard.

(2) A consulting service to give him this assurance when indicated. The service should be credible and readily available.

(3) An educational process whereby his level of awareness of occupational health hazards is raised and maintained. Without such an educated work force no organization, no matter how well it is structured, can be effective in assisting the worker to act in a safe way.

(4) A system for monitoring his health to prevent and detect illness where his employment places him at particular risk. This may take the form of periodic physical examinations or laboratory tests. In either case, the worker should know the results of these tests.

(5) Treatment of illnesses arising out of his work.

(6) A method of assessing the effects of illness on him. The assessment should state objectively and credibly:
   a. The resultant impairment, if any, to his health.
   b. The resultant disability, if any, to perform his work.
   c. The resultant disability, if any, in absolute terms, *i.e.* in relation to a healthy and whole man.

(7) A process of compensation which takes into account these assessments.

(8) A process of rehabilitaton from such illnesses which if unable to restore him to his prior state of health, will aim to restore him to his prior state of earning capacity.

(9) Access to an "intelligence service" that would collate data, statistics, world wide literature and other information relative to occupational health and be capable of transmitting this information to those concerned.

(10) Access to research that will produce realistic standards of working conditions.

SOURCE: Alberta: Industrial Health and Safety Commission 1975. *Report.* 1975:98–100.

CONSUMER RIGHTS IN HEALTH CARE

I Right to be informed

1 — about preventive health care including education on nutrition, birth control, drug use, appropriate exercise
2 — about the health care system including the extent of government insurance coverage for services, supplementary insurance plans, and referral system to auxiliary health and social facilities and services in the community
3 — about the individual's own diagnosis and specific treatment program including prescribed surgery and medication, options, effects and side effects
4 — about the specific costs of procedures, services and professional fees undertaken on behalf of the individual consumer

II Right to be respected as the individual with the major responsibility for his own health care

— right that confidentiality of his health records be maintained
— right to refuse experimentation, undue painful prolongation of his life or participation in teaching programs
— right of adult to refuse treatment, right to die with dignity

III Right to participate in decision making affecting his health

— through consumer representation at each level of government in planning and evaluating the system of health services,
— the types and qualities of service and the conditions under which health services are delivered
— with the health professionals and personnel involved in his direct health care

IV Right to equal access to health care (health education, prevention, treatment and rehabilitation) regardless of the individual's economic status, sex, age, creed, ethnic origin and location

— right to access to adequately qualified health personnel
— right to a second medical opinion
— right to prompt response in emergencies

SOURCE: *Canadian Consumer* 4, April, 1974:1.

EXCERPTS FROM ALBERTA ASSOCIATION OF REGISTERED NURSES, POSITION PAPER ON NURSING, 1975.

Independent Role of the Nurse

In performing independent functions, the nurse makes judgements based upon her education, training and experience. Professional nursing is a service discipline characterized by decision-making processes, which are critically dependent upon sound theoretical knowledge. The goal of the professional discipline is service. The nurse actively participates in programs of health maintenance and health promotion.

Central to nursing is the responsibility for caring. To fulfill the caring functions, the nurse possesses skills as an educator, supervisor, counsellor, coordinator and implementor of nursing and health care. Working alone or with others the nurse assists the patient to meet his health care needs. Patients/clients participate in decision-making regarding their care.

Dependent Role of the Nurse

Dependent functions are performed under the legal orders of a duly qualified physician and within the policies of the employing agency. The nurse has an obligation to question orders which she may not clearly understand or which, in her judgement, may seem inappropriate in light of current observation and information about the patient or situation.

Collaborative Role

The nurse works interdependently with other members of the health care team to meet the patients/clients health care needs. This process is dependent upon mutual understanding of the contributions each member makes within the health care system.

SOURCE: Alberta Association of Registered Nurses. "Position Paper on Nursing". Edmonton. March, 1975:5.

EXCERPTS FROM THE REPORT OF THE COMMITTEE ON NURSE PRACTITIONERS, 1972

Primary health care refers to that section of the health care system which most of the people use most of the time for most of their health problems. It is the common entry point into a comprehensive health care system.

The term, PRIMARY HEALTH CARE, is used here to mean all of those health services which are provided for individuals mainly on an ambulatory basis in the community or in their homes and includes: preventive and health maintenance services in the community; diagnostic and therapeutic services offered in physicians' offices, in clinics or in health centres; home care services for those who are ill; and rehabilitative services for those who require them. It provides care which is convenient, co-ordinated, continuous and comprehensive.

Although much of this care has been associated with the family doctor of yesteryear, the trend has been for more and more health professions to become involved with the provision of primary care and for the increasing transfer to them of functions previously provided solely by physicians, as well as the provision by them of services not previously rendered by the physicians. These developments have been gradual and initially the use of other professions was seen as the introduction of a "physician extender". The awareness of the unique contribution that other professions can make in the provision of patient care is, however, becoming more and more widespread and is being gradually translated into corresponding increased responsibility and autonomy for these professions.

These developments in the perception of the role of the various health professions have not been identical everywhere nor with everybody and, in reviewing the briefs submitted to the Committee, it was apparent that the term NURSE PRACTITIONER had been interpreted in two different senses. At one extreme, the term was taken to mean the recognition of an expanded and well-defined role for nurses as nurses, and on the other, the utilization of nurses to assist physicians in carrying out *their* functions. . .

From the briefs submitted to the Committee and the content of already established programs, there emerged a common consensus regarding certain functions which the Nurse Practitioner, with suitable training and experience, could undertake in primary health care:

1. The Nurse Practitioner can be the initial contact for people entering the health care system, that is, she can be the first health professional the individual sees.

2. As first contact, the Nurse Practitioner should be able to assess the individual's health status to determine the need for medical, nursing or other intervention.

3. The Nurse Practitioner should be able to initiate treatment for patients with commonly occurring health problems which lie within her scope of competence or to arrange for the referral of patients to the appropriate health professional (or agency) as needed.

4. The Nurse Practitioner should be able to counsel people of all age groups in relation to health matters.

5. The Nurse Practitioner should be able to teach individuals and families the specific knowledge and skills they require to maintain health and prevent illness, or to care for themselves or a

family member in the event of illness and assist in their recovery and rehabilitation.

6. The Nurse Practitioner should be able to undertake the care of normal healthy women throughout the maternity cycle, including antepartum and postpartum supervision and counselling and, with additional specialization in midwifery, perform normal deliveries.

7. The Nurse Practitioner should be able to supervise the health care of well children.

8. The Nurse Practitioner should be able to supervise the health care of older people, except as they require medical intervention in the case of acute illness.

9. The Nurse Practitioner should be able to monitor patients with stabilized long-term or chronic illnesses and in consultation with the physician to adjust or modify treatment as indicated.

10. The Nurse Practitioner should be able to co-ordinate the health care of individuals and families through referral to appropriate health professionals and/or agencies as needed and follow-up of patients post-referral.

11. The Nurse Practitioner should be able to intervene in crisis situations, that is, to take action within her scope of competence or to refer the individual (or family) to the appropriate health professional or health agency for assistance.

This list of functions which the Nurse Practitioner should be able to undertake implies a much broader range of activity than has been the case in the traditional role of the nurse in primary care. *It also means that the Nurse Practitioner will exercise more independent judgement than has been permitted heretofore.* Although many nurses have functioned and are functioning in an expanded role in differing situations, often without the benefit of additional preparation beyond their basic nursing course, it is felt that many more nurses could be prepared and utilized as Nurse Practitioners to extend the services provided for the public in the primary care field.

The amount of responsibility the Nurse Practitioner carries, and the extent to which he or she is permitted to exercise independent judgement will vary, depending on the situation and the confidence and trust engendered in patients and colleagues.

. . .

. . . In examining the needs of the public for primary health care and the roles that the various health professions fill, the Committee is of the opinion that we should capitalize on the natural developments that are already taking place in our health care delivery system and in our health professions. Instead of suggesting the development of an entirely new category of worker, or a new profession, the Committee in its deliberations stressed two basic issues.

The first of these is seen as the gradual change of our health care system. The concept of the Nurse Practitioner is fundamentally linked to that of the multidisciplinary team. In the team concept it is recognized that each of the different health professions has its own unique contribution to make in health care, and it is only through the combined effort of all members of the team that the goal of comprehensive health care can be achieved.

The multidisciplinary team is seen as an organizational innovation which is well suited to provide this care.

The second basic issue is the need for a gradual adaptation of the educational system for preparing health professionals. Educational institutions which prepare practitioners for the health field must respond to societal needs. In assessing these needs in relation to primary health care services, it is the Committee's opinion that there are unmet needs in this area which can best be served through the introduction of Nurse Practitioners.

The Committee recommends:

1. That the multidisciplinary health team concept be implemented in order to improve the accessibility, comprehensiveness, co-ordination and personalization of health services, especially at the primary care level.

2. That nurses integrated thus into multidisciplinary teams, as nurse practitioners functioning in an expanded role (as outlined in the body of this report), bring their specific contributions to bear to make the team concept a reality.

3. That the development of the nurse practitioner category be regarded as the highest priority in meeting the primary health care needs in Canada.

4. That the functions of nurse practitioners be performed by the best prepared persons available in terms of education and experience, and according to the needs of the population without being rigidly tied to any specific level of education.

5. That the basic preparation of nurses, both at diploma and university levels, be suitably modified to reflect this broadened concept of nursing.

6. That, until changes in basic nursing education are reflected, candidates interested in a career as nurse practitioners receive special preparation through supplemental programs of a formal nature in educational institutions affiliated with the university health science centre.

7. That the development of these supplemental courses be undertaken conjointly by Faculties of Medicine and of Nursing.

8. That, since widespread acceptance of nurse practitioners is dependent on attitudinal changes in the existing health professions, the rate of development be gradual.

9. That pilot or demonstration projects utilizing nurse practitioners be developed in many parts of the country and appropriately evaluated.

10. That remuneration of nurse practitioners be by salary and at the levels comparable to other sectors of nursing practice with similar degrees of responsibility.

11. That federal and provincial governments take the necessary financial and administrative measures to create strong incentives towards development of health centres based on the concept of the multidisciplinary health team.

12. That provinces be encouraged to establish special task forces, composed primarily of representatives of the medical and nursing professions, to deal with problems related to transfer of functions, including legal aspects, as these concern the role of the nurse practitioner.

SOURCE: Boudreau, T. *Report of the Committee on Nurse Practitioners.* Ottawa: Department of National Health and Welfare, April, 1972:2, 6-7, 13-14.

Appendix D:1

NURSING AIDE PROGRAM

COURSE TITLE	Lecture Hours	Field Trip Hours	
Nursing Arts	215	8	Includes:
Environmental Health	25		Films
Food Science	25		Examinations
Medicine and Surgery	60		Quizzes
Paediatrics	40		Lab. Experience
Obstetrics	40		
Psychology	20		
Psychiatry	20		
Geriatrics	25		
Emergency Nursing	10		
Ethics	25		
Anatomy and Physiology	55		
Orientation and Registration	2		

First 19 weeks of Program are spent in the School, with a field trip of 8 hours to an Auxiliary Hospital (Total – 600 Hours)

ACTIVE TREATMENT HOSPITALS	Patient Care Hours	Lecture Hours	
Clinical Experience:			
Paediatrics	175	25	
Obstetrics	175	25	
Medicine	175	25	
Surgery	175	25	

Patient Care – 700 Hours
Lectures – 100 Hours

(Total – 800 Hours)

SOURCE: Alberta Vocational Centre, Edmonton. Faculty of Nursing Orderly Program. "The Preparation and Articulation of Health Care Workers Educated in Short Term Program." A Position Paper to the Alberta Task Force on Nursing Education. Edmonton. June, 1975:20.

Appendix D:2

NURSING ORDERLY PROGRAM

PHASE 1 — 20 WEEKS — "The Role of the Nursing Orderly in an Auxiliary Hospital"

	School Content					
COURSE TITLE	Lecture Hours	Lab Hours	Audio-visual Hours	Field Trip Hours	Exams and Quiz Hours	Total Course Hours
The Physical Body	49				3	52
Meeting the Emotional Needs of People	20		7		3	30
The Nursing Orderly on the Nursing Team	8				2	10
The Physical Needs of Man	15		2	10	3	30
Introductory Microbiology and Community Health	17	6	4		3	30
Caring for Patients with Long Term Illnesses	32		5		3	40
Nursing Procedures	40	100	12		3	155
					13 Review	

Lectures (Guest & Instructors)	—	181 hrs.	
Lab	—	106 hrs.	
Audio-visual Aids	—	30 hrs.	
Field trips	—	10 hrs.	
Examinations, Quizzes and Reviews	—	33 hrs.	(TOTAL — 360 hrs.)

AUXILIARY HOSPITALS	Patient Care Hours	Clinic Presentations Discussion Hours	Field Trip Hours	Exams and Quiz Hours	Total Course Hours
CLINICAL EXPERIENCE	265	40	10	5	320

Patient Care	—	265 hrs.	
Clinic Presentations and Discussions	—	40 hrs.	
Field Trips	—	10 hrs.	
Examinations, Quizzes, and Reviews	—	5 hrs.	(TOTAL — 320 hrs.)

(continued)

PHASE II 20 WEEKS "The Role of the Nursing Orderly in an Active Treatment Hospital"

	School Content					
COURSE TITLE	Lecture Hours	Lab Hours	Audio-visual Hours	Field Trip Hours	Exams and Quiz Hours	Total Course Hours
Meeting the Emotional Needs of People	16	3	3		3	25
Orthopaedic	19	10	3		3	35
Urology	19	10	3		3	35
First Aid	9	8	2		1	20
Caring for Patients with Short Term Illnesses	35		5		3	43
Obstetrics (Normal and emergency delivery)	5	1	1			7
Nursing Procedures	10	30			10 Review	50

Lectures (Guest & Instructors)	–	113 hrs.	
Lab	–	62 hrs.	
Audio-visual Aids	–	17 hrs.	
Examinations, Quizzes and Review	–	23 hrs.	(TOTAL – 215 hrs.)

ACTIVE TREATMENT HOSPITALS	Patient Care Hours	Clinic Presentation Hours	Lecture Hours	Field Trip Hours	Exams and Quiz Hours	Total Course Hours
CLINICAL EXPERIENCE	375	6	71	22	6	480

Patient Care	–	375 hrs.	
Clinic Presentations	–	6 hrs.	
Lectures	–	71 hrs.	
Field Trips	–	22 hrs.	
Examinations and Quizzes	–	6 hrs.	(TOTAL – 480 hrs.)

SOURCE: Alberta Vocational Centre, Edmonton. Faculty of Nursing Orderly Program. "The Preparation and Articulation of Health Care Workers Educated in Short Term Programs." A Position Paper to the Alberta Task Force on Nursing Education. Edmonton. June, 1975:18–19.

PSYCHIATRIC NURSE PROGRAMS

ALBERTA HOSPITAL PONOKA

1st Year Courses

Nursing 1 – 110 hrs. plus
Pharmacology – 60 hrs. = 170 hrs.

Nursing I provides the information and experiences essential to basic physical nursing care. It incorporates and integrates the subjects of Pathology, Microbiology and Nutrition. Included are development of observation skills, charting, problem-solving, communication, development of professionalism and manual skills.

Pharmacology is included as a major subject under the heading of Nursing I. This course stresses understanding of administration, action of, and side effects of drugs.

Anatomy & Physiology – 90 hrs.

Anatomy and Physiology instruction is to provide the student with a general knowledge and appreciation, and a scientific understanding of the structure and function of the healthy human body.

Psychiatric Nursing I – 110 hrs.

Psychiatric Nursing provides the student with a knowledge of mental health concepts including illness and wellness, concepts of social, psychological, and physiological human behavior. It also provides the student with the background knowledge to provide supportive psychiatric nursing care.

Introductory Psychology – 65 hrs.

Introductory Psychology provides the student with a scientific knowledge and basic understanding of normal human behavior. Specific emphasis is placed on growth and development, perception, principles of learning, motivation and emotion.

Introductory Sociology – 70 hrs.

Introductory Sociology studies man in his environment. It is designed to give the student an appreciation of the mechanism that maintains man in society. The student is provided knowledge in the areas of illness and health effects on society, the influence of a changing environment on individual behaviour, social stratification and its influence on cultural expectations.

Sociology of the Family – 34 hrs.

Sociology of the Family outlines the effects of various sociological factors on the development of an individual within the family setting; skills in recognizing and understanding the dynamics of the family as an institution will be developed. The consequences to the family of modernization, the new directions caused by ferment and change, and the prospects of the future will be basic elements in this course.

Introductory Pathology – 35 hrs.

This course is to provide the student with signs and symptoms of abnormal behavior. The content is designed so that the student can recognize various types of disease entities in the clinical area.

Theories of Personality – 40 hrs.

Personality theory instruction provides the student with various theoretical frameworks for the study of personality. It includes determinants of personality, assessment and interpretations of psychopathology according to the individual theories.

2nd Year Courses

*Psychiatric Nursing II – 355 hrs.

This course is designed to further develop skills in self expression, assisting others in self expression, practical application of knowledge of approaches to illness and to provide a greater understanding of interpersonal relationships. The course specifically stresses the identification of patients' needs and the nursing interventions to meet these needs.

Family Dynamics – 60 hrs.

Family Dynamics provides the student with the knowledge and understanding of familial behavior which includes family interaction and communication patterns. Focus is on the methodologies used in effecting modification of pathological behavior.

Psychopathology – 100 hrs.

Advanced Psychopathology provides the student with concepts of abnormal or maladaptive behavior. Included are the development, casualty, and adjustment in both adaptive and maladaptive functioning of the individual. The student gains a knowledge of clinical pictures, causal factors and outcomes of various types of maladaptive patterns.

Systems of Psychotherapy – 70 hrs.

Psychotherapy provides the student with the knowledge and understanding of various techniques of individual and group psychotherapy. The approach to various therapies enables the student to gain experience in functioning effectively within ongoing treatment programs.

Nursing II – Medical-Surgical Nursing – 110 hrs.

The student is given the opportunity to develop the knowledge, skill, and attitude required to adapt nursing care to the individual patient who has a physical illness. Focus on the practical application of nursing skills to planning, implementing and evaluating nursing interventions necessary to assist the patient back to health. Special focus is placed on Medical-Surgical nursing of adult and geriatric patients.

* Psychiatric Nursing – 137 hrs. lecture time plus 218 hrs. practicum. Practicum includes clinical experience with special emphasis on the Care of Adolescents, Community Nursing, Rehabilitation in the area of Alcoholism, Drug Abuse, Geriatric Nursing, Administration, plus 60 hours in Human Relations Workshops.

ALBERTA HOSPITAL EDMONTON

First Year

Orientation to Psychiatric Nursing	20 hours
Human Biology	60 hours
Introduction to Psychology	50 hours
Normal Growth and Development	40 hours
Introduction to Sociology	60 hours
Interrelated Psychiatric Nursing I	75 hours
Fundamentals of Nursing Care	70 hours
Introduction to Group Processes	50 hours
	425 hours

Second Year

Interrelated Medical-Surgical Nursing	100 hours
Interrelated Psychiatric Nursing II	125 hours
Theories of Personality	30 hours
Behaviour Therapy	10 hours
Introduction to Group Therapy	50 hours
Professional Leadership	30 hours
Social Problems	70 hours
	415 hours

TOTAL HOURS	840
Each student receives an average of 150 hours of planned clinical teaching, during the two-year program.	150 hours
TOTAL HOURS	990

July 1975

Appendix D:4

DIPLOMA NURSING PROGRAMS

	A. CURRICULUM		DIPLOMA PROGRAMS — COLLEGES		
	Length	Level of Preparation	Nursing Role Being Prepared	Transferability of Credit	Courses being shared with students in other disciplines.
GRANT MacEWAN COLLEGE	75 weeks	Diploma in Nursing - eligible for registration	Total patient care. Management skills in organizing direct patient care. Beginning staff level nurse.	Transferability from other college level nursing programs is possible on an individual basis. Transferability to Baccalaureate nursing programs (U. of A.); graduates of our College are granted two year blanket credits towards the baccalaureate degree. To other non-nursing programs in universities; approximately 8 non-nursing courses could be transferable in some faculties of the university providing they are relevant to the program that the student applies for.	Ten courses from the general education area can be shared with students from other disciplines within the College.
LETHBRIDGE COLLEGE	78 weeks	Diploma in Nursing - eligible for registration	Capable of giving safe direct care to patients. Capable of functioning at a beginning staff nurse level. Not prepared to assume administrative positions. Aware of her own need to continue learning to improve nursing practice. Has sufficient basis in life and natural sciences to transfer into higher education in nursing if desired.	Transferability between diploma program (hospital-based, College) is on an individual basis considering comparability of course content and sequence. Transferability to baccalaureate nursing programs - U. of A. grants two years toward a baccalaureate degree (Post-Basic Program). Transferability to non-nursing programs - assessed on the basis of non-nursing courses which are of "University transfer" level and are relevant to the program under consideration. University of Lethbridge - in the first arrangement of its kind in Alberta, nursing students at the Lethbridge Community College receive unspecified credit for 10 semester courses equal to one year of a B. Ed. or B. A. or B. Sc. program.	Six general education courses.
MEDICINE HAT COLLEGE	74 weeks	Diploma in Nursing - eligible for registration	Safe, competent total patient care. Management skills in organizing direct patient care. Beginning staff level nurse.	Transferability from other college level nursing programs is possible on an individual basis. Transferability to Baccalaureate nursing programs (universities of Alberta and Calgary); graduates are granted two year blanket credits towards the baccalaureate degree.	Eleven courses from the general education area can be and/or are shared with students from other disciplines within the college.
MOUNT ROYAL COLLEGE	72 weeks	Eligible to write Conjoint Exams for Nurse Registration, & obtain a Diploma in Nursing	Beginning level staff nurse to fulfill positions in hospitals should be able to give total patient care, as well as possess management skills in organizing direct patient care.	Transferability exists between: diploma nursing programs, with assessment for credit being carried out on an individual basis, and particular course sequence of programs involved. Transferability to baccalaureate nursing programs is generally based on being able to meet the entrance requirements of the institution offering the degree program. No credit is obtained at this time for our nursing courses, but student may obtain credit for particular arts and science courses considered to be "university transfer" courses between Mount Royal College and University of Calgary.	Nine courses
RED DEER COLLEGE	78 weeks	Diploma in Nursing - eligible for registration	Prepared for beginning staff level nursing positions in hospitals and health agencies; prepared to give total nursing care to patients, and has management skills in organizing direct patient care.	Between diploma nursing programs, the student is assessed on an individual basis if transfer is requested. From diploma program into post-basic B. Sc. (N) program at the U. of A., there is transferability by total program (not on course by course basis). To non-nursing programs i.e. B. A., B. Sc. - at the completion of the program the Red Deer College graduate has eleven university transfer half courses which may be applied to a baccalaureate degree.	Shares 12 half-courses with students from other disciplines. (One of the non-transfer course is shared with students in Social Service).

	B. TEACHING ARRANGEMENTS General Education Courses	Nursing Courses: Theory & Laboratory	Nursing Practice	Instructor-Student Ratio
GRANT MacEWAN COLLEGE	English, Introductory Psychology, Developmental Psychology, Introductory Sociology, Biology are taught by instructors having expertise in the respective courses rather than by nurses. These courses are taken with other college students.	Minimum of 350 hours theory and 120 hours laboratory is included in the program.	Minimum of 950 hours of clinical experience is included in the program.	Class room faculty-student ratio is between 1:8 and 1:70. Clinical experience faculty-student ratio is between 1:6 and 1:15.
LETHBRIDGE COLLEGE	Year I: Trimester I: Biology (Anatomy & Physiology), Physical education, Psychology. Trimester II: Biology, Growth and Development Trimester III: Composition. Year II: Trimester I: Microbiology, Sociology. Trimester II: Elective, Abnormal Psychology. Trimester III: None.	Total of 377 hours.	Total of 1,430 hours.	Classroom – maximum 1:80 Simulated lab. – maximum 1:20 Clinical practice – average 1:8
MEDICINE HAT COLLEGE	English, Introductory Psychology, Developmental Psychology, Introductory Sociology, Microbiology and Philosophy are taught by instructors with expertise in these courses rather than by nurses. Students other than nursing students share in these courses. Electives, of which there are two in general education, are other courses in the above mentioned ones. In addition it can be from other offered courses, such as anthropology, chemistry and biology. Natural Science is a required course designed for nursing students and is taught by a non-nurse with expertise in that area.	Minimum of 376 hours.	Minimum of 944 hours.	Classroom 1:36 and 1:45 Clinical between 1:6 and 1:13
MOUNT ROYAL COLLEGE	Biology (Human Anatomy and Physiology, disease and parasitism), English, Psychology and Sociology. Also two elective courses totaling 6 credits. Examples of electives frequently taken are: Physical education (athletic injuries) and Behavioural Science (Abnormal psychology).	Total of 393 hours	Total of 786 hours.	Classroom – maximum 1:80, minimum 1:5 Seminar – maximum 1:20, minimum 1:15 Clinical – maximum 1:10, minimum 1:6
RED DEER COLLEGE	All non-nursing courses are taught by experts in the specific discipline. These supportive courses include the following half courses: English, 2 courses; Sociology, 2 courses; Psychology, 3 courses; Physiology, 2 courses; Microbiology, 1 course; Genetics, 1 course; Electives, 2 courses. Students with advanced standing may substitute other courses for the required courses noted.	Total of 330 hours	Total of 1,315 hours.	Varies with learning experience and level of experience of the student. Ranges from 1:15 in some terms to 1:8 in others.

	C. CLINICAL RESOURCES How Obtained: Where and What Outside Sources	Commitment (specific schedule, specific units, etc.) Arrangements, Contracts.	Extent They Meet the Educational Objectives. Quality of Experience.
GRANT MacEWAN COLLEGE	The kind of experience obtained in health agencies varies between observation visits and practical experience time. Nursing homes and auxiliary hospitals are used for beginning nursing skills. Acute care hospitals are used for more complex nursing skills and for learning about more complex clinical conditions. The community facilities are used throughout the entire program for the students to acquire an understanding of health services within the community. Contracts are used for institutions where clinical experience is acquired through practice. Other institutions or agencies used for observation visits: arrangements are made through letters or telephone followed up by letters.	Students are supernumerary throughout their entire program. However, the last summer session provides for time when students actually can assume the role of a full-time employee.	All learning experiences are exactly that: learning. No experience is part of the program which does not have a definite learning objective.
LETHBRIDGE COLLEGE	Lethbridge Auxiliary Hospital, Southland Nursing Home, St. Michael's Hospital, Lethbridge Municipal Hospital, Fort Macleod General Hospital, Blood Indian Hospital, Cardston, Medical Practitioner's offices, Claresholm Care Centre, Alberta Provincial Hospital, Ponoka.	Clinical facilities are contracted annually. Students are supernumerary. Opportunities are offered in Nursing 213 to function at staff nurse level prior to graduation.	Adequately. With the entry to the program of 3 classes a year (30 students each Trimester commencing Fall 1975) there will be less pressure upon Pediatric and Obstetric facilities and "busing" students to outlying areas (Cardston) Fort Macleod, will be minimized.
MEDICINE HAT COLLEGE	Health agencies in the city and elsewhere: experience in observation and practical experience time. Nursing homes and auxiliary hospitals used for beginning nursing skills. Acute care hospital used for more complex nursing skills and for more complex clinical conditions. The auxiliary hospital is also used for rehabilitative nursing experience. Also, selected patients in the nursing homes are used for psychiatric nursing experience. Experiences are limited in: sick children and specialized clinical areas e.g. dialysis units, neurology, neurosurgery. Contracts are used for the institutions where clinical experiences for students are acquired through the giving of patient care. Other institutions or agencies used for observational experiences are arranged by telephone, visit and letters.	Through discussions with administrative staff of the respective agencies arrangements are made concerning specific schedules for student clinical experience times and the required specific service areas of the experience. Students are supernumerary throughout the program. In the last summer session the student begins to assume the role of a full-time staff member.	Objectives are plainly stated, written and given to students at the beginning of each clinical experience. Each experience is evaluated in terms of these objectives. Students objectives are considered also in the selection and evaluation of the clinical nursing experience.
MOUNT ROYAL COLLEGE	Calgary General Hospital – used for medical-surgical nursing, pediatrics, maternal and child care and psychiatry. Bethany Auxiliary Hospital — used for fundamentals of nursing. Salvation Army Grace Hospital — used for Maternal-child care experience. Rockyview Hospital — used for 2nd year medical-surgical experience. Foothills Hospital used for psychiatry.	Clinical facilities are contracted on a semester basis with each individual hospital, therefore continuous negotiations are being carried out. We can request specific units and generally our requests are being met, however there is some competition for use of facilities with University of Calgary, specifically in specialty areas such as pediatrics & psychiatry.	It has generally been felt that the amount and quality of experience has been adequate so that the students are able to meet the educational objectives — Pediatrics has been the one area of concern where we would like to obtain additional experiences for our students, but this is in part due to the fact that University of Calgary is also in the areas at the same time as our students.
RED DEER COLLEGE	The bulk of clinical experience is obtained at Red Deer General Hospital. Extended care experience is obtained at the Richard Parson's Auxiliary Hospital. Affiliation with Alberta Hospital, Ponoka, is used in relation to psychiatric care. Many community health agencies are used to supplement the institutional experiences, i.e. C.M.H.A. Lifeline program, Public Health unit, V.O.N., nursing homes, ASH/Deerhome, etc.	Commitments from clinical agencies are made on the basis of a contract between the college & institution involved. As the bulk of experience is obtained at the R.D.G.H. & R.P.A.H., an overall, general contract is in force, and arrangements for use of specific units made on a semester by semester basis & verified by letter. Short term experiences are covered by letters of agreement specifying the experiences arranged. The College carries insurance for students & instructors.	To date we have been able to obtain sufficient clinical experience to meet the program objectives. The student enrollment has been limited to ensure adequate experience for the class. An adjustment in sequence of some experiences would allow expansion, if this becomes advisable in the future. When Alberta Hospital — Ponoka reduced the time they would allow us to affiliate students, we were able to pick up a first level community psychiatric nursing experience through the lifeline program of the Canadian Mental Health Association. Opportunity for adequate experience in labor & delivery care has been enhanced by a) using follow through assignments with expectant families, b) placing students "on call" for additional experience under supervision of the obstetrical staff & c) by dividing the lab.

	D. ADMINISTRATION Entrance Requirements	Selection Procedures	Withdrawal Policies	Budget	Faculty Employment and Tenure Policies	Educational Preparation of Faculty. Number and Levels.	Costs, Fees.
GRANT MacEWAN COLLEGE	Regular students are admitted providing they possess an Alberta high achool diploma including English & Biology with an average of at least 60%.	Students possessing a straight-forward record as described are admitted to the Nursing Program through the Registrar's Office. Group information sessions are held for applicants instead of individual interviews.	Students expected to obtain credit in all courses in order to be promoted to the next trimester.	Source of funds comes from college grant received from Dept. of Advanced Education. Budget includes instructional personnel for nursing courses, travelling expenses, meeting expenses, honorarium, etc. These are part of operating budget; also a capital budget for equipment etc.	College advertises, interview panels select applicants. Tenure policies: new employees are hired for a year contract during two consecutive years prior to being granted a 5 year cyclical tenure.	Minimum of baccalaureate degree. There is a total of 12 full-time instructors and five half-time instructors. The Chairman has a Master's degree in nursing administration.	$100.00 per trimester $60.00 per summer session for a total of $520.00 for 2 years Student association fees of $12.00 for four trimesters. Board & room not provided by College neither is transportation.
LETHBRIDGE COLLEGE	Alberta high school diploma (100 credits) or equivalent with 60% minimum average in the four required courses and not less than 50% in any subject as follows: English 30, Biology 30 or Chemistry 30, and two other subjects e.g. Physics 30, Maths 30 etc.	"Open door" policy as long as the entrance requrements are met. None of the following used for selection purposes: individual or group interviews; test; letters of reference. Applications are processed by the Dept. of Student Services.	Students requested to withdraw if a passing grade is not obtained in all courses in the program. In nursing courses a passing grade must be obtained in the clinical portion of the course as well as in the class in order to obtain a passing grade. The Chairman, in consultation with faculty, have the authority to ask students to withdraw on the basis of nursing performance.	Approved by Dept. of Advanced Education and Board of Governors. Budget projections made by Dean of Instruction in consultation with Chairman of Nursing Program. Chairman is accountable for expenditures on the operational budget. (staff development, travel, supplies, telephone, etc.)	Initially on a year by year basis for a two year probationary period. Third year — "without definite term" is accorded on recommendation of the President in consultation with Directors & Chairpersons.	The Chairman has a Master's degree in nursing administration, & Ph. D. in education. 7 full-time faculty — minimum baccalaureate degree. 8 sessional instructors (used in clinical areas only) R. N. plus average of 5 years of experience.	$437.50 (6 trimesters) Student association fees – $30.25/semester. Other expenses — room & board, uniforms, books & supplies, recreation.
MEDICINE HAT COLLEGE	Alberta high school diploma with an average of at least 60%.	Initial screening through Registrar's office; individual and small group interviews.	Students are expected to obtain credit in all courses in order to be promoted to the next semester. Midterm evaluations (instructor & student self evaluation) are used to advise withdrawal of students who are demonstrating difficulty in achieving the standard.	Approved by Dept. of Advanced Education and the College Administration. This is the operating budget. A capital budget is prepared for equipment and furniture when required.	Re-appointed yearly. Nursing faculty are interviewed by Director. All faculty positions open are advertised. Interview panels for suitable applicants. New employees are hired conditionally for a year contract.	Minimum of baccalaureate. Three teachers have Master's degree, two have clinical specialties and one specialized in administration and curriculum development in school of nursing.	$100.00 per semester No charge for summer session except in case of repeat. Board, room and transportation are responsibility of student. Students association fees $40.00 per year.
MOUNT ROYAL COLLEGE	Alberta high school diploma. 60% average and a mark no less than 50% in: English 30, Biology 30 and two of the following: Chemistry 30, foreign language 30, Maths 30, Physics 30.	Minimum academic standards will be reviewed in light of the following criteria: Number of supplemental examinations written; references & transcripts from other post-secondary institutions attended; number of 30 level subjects presented; family or medical circumstances.	Students who withdraw from their nursing subjects in any semester are no longer regarded as nursing students of record and have to apply for re-admission to the program if they wish to continue with nursing at a later date. Extenuating circumstance surrounding the withdrawal the student may petition the Chairman.	Department of Advanced Education allocates budget to the College.	Yearly contractual basis and are eligible to apply for tenure after 14 months. Not compelled to apply for tenure, and if this is the case has his/her contract renewed on a yearly basis.	4 full time faculty members with B. Sc. in nursing. The Chairman at Masters level.	$115.00/semester. All Expenses of maintaining themselves in the program are borne by the student.
RED DEER COLLEGE	100 high school credits. Must present Biology 30, English 30 and three other matriculation subjects with a minimum overall average of 60% in the five presented.	Selection based on testing and interview results, academic credentials and date of application. A serious health problem which is not under control may exlude an applicant.	May withdraw voluntarily. If fail nursing theory, are unsatisfactory in nursing practice, or are not able to pass supportive courses the student is asked to leave the program. Any student who is asked to leave the program may re-apply. Re-admission is not automatic nor guaranteed.	Financed from student tuition fees and the Department of Advanced Education. Both Capital and operating budgets are prepared and approved on an annual basis.	No tenure as such. Following a two year probationary period, the faculty member may be offered a 5 year cyclic term of employment, and may be re-appointed for additional 5 year terms as warranted.	Director at Masters level. 8 full-time instructors with a minimum of baccalaureate degrees. 3-4 lab assistants for a term/year, usually have B. Sc. nursing.	$610.00 for the two years. Student is responsible for all personal costs for books, uniforms, room and board, in-town transportation & general personal expenses. College provides all out-of-town transportation.

	E. SUPPORT SERVICES Recruitment, Enrollment & Registration	Library Management – Extent of Holdings.	Audio – Visual Aids	Research (curriculum, students etc)	Graduation Ceremonies
GRANT MacEWAN COLLEGE	These activities are the responsibilities of the Registrar's Office. Input from the Nursing Department is always available.	Two fully-prepared professional librarians are available as well as librarian assistants. These services are available on a central basis as well as on a campus basis. The number of books in the nursing area available at Scona Campus is approximately 750 books.	The Audio-visual department in the college provides the budget, storage, maintenance and entire service for the audio-visual aides. These audio-visual aids can be used by the instructor in the classroom and also a large number are available in the Learning Resource Centre for the students' use.	A five year evaluation project for the nursing program is underway. The results will provide an evaluation of the curriculum and the performance of the graduates.	Graduation ceremonies with entire college and wear the graduation attire of other graduates of the College.
LETHBRIDGE COLLEGE	Registration – all applications are processed by the Department of Student Services. Recruitment public relations officer of the college. Brochures to High Schools in Southern Alberta, Radio, TV, Career Days etc. Chairman – speaks as she can at High Schools when requested.	Director of Library Services (professional librarian) with 6 support staff. 25,000 print items, 500 periodical titles and 2,000 non-print items. Nursing holdings are adequate. All faculty members order what they require.	Department of Audio-visual Aids, under the direction of the Director of Library Services. 1 A-V specialist and 1 support staff. Services nursing program as it services other programs in College (films, concept loops, making films, transparencies, etc.) Increasing use of auto-tutorial instruction in the fundamental part (Trimester 1) of the curriculum.	Follow-up study of graduates completed in 1974-75 (previous director). Research project to upgrade clinical conferences in the clinical setting (present Chairman) Proposed study of graduates of the program to be conducted by a Ph. D. candidate. (Director of a community college program) On-going study by department of student services.	Same Commencement Exercises as all other students. Students eligible for general award and awards specified to nursing program (totaling $1,000.) Students receiving their nursing pin at the ceremonies.
MEDICINE HAT COLLEGE	These activities are primarily the responsibility of the Registrar's office. Frequent consultations occur and selected applicants are reviewed jointly.	Two fully qualified librarians plus librarian assistants. Excellent resources in a Learning Resources Center on campus which is shared by other students and contains a large number of nursing books. Library provides the budget, storage, maintenance and services to teacher and student.	The Instructional Media Centre (IMC) in the College provides the entire service for audio-visual aids which may be used by the instructor. The IMC staff also take the responsibility of ordering special films on a short-term borrowing basis. A beginning in programmed instruction has been made. Slides and video-tapes are made.	A research project is underway on establishing a reliable tool for the evaluation of clinical nursing performance. This is done in conjunction with a psychology doctoral student from Simon Fraser University. This present tool is being used against the objectives for each of the six nursing courses by both teacher and student.	Graduation ceremonies by the college and wear uniforms.
MOUNT ROYAL COLLEGE	Annual Open House – no specific recruitment program other than information supplied from registrar's office. Take in 80 students each fall – registration responsibility of Registrar's Office with assistance of nursing advisors to advise individual students.	Managed by College. Extensive Nursing holdings, adequate budget to maintain resources. Extensive supporting, non-nursing references.	Extensive use of audio-visual aids as well as potential for developing numerous variety of audio-visual aids. Audio-visual aids part of basic concept utilized in learning Model of Mount Royal College.	On-going research project involving the class entering fall of 1973, to determine success predictions in performance in nursing. Graduates will be followed for two years in the work situation.	Nursing students part of total college graduation ceremonies at the completion of the academic year. Nursing students themselves arrange for their own graduation festivities.
RED DEER COLLEGE	Nursing faculty participate in general recruitment and publicity activities. These are organized through the Student Services department. Enrollment & registration are handled through the Registrar's office with involvement of Nursing faculty i.e. program and course approvals are from the nursing department.	Library books & resources for nursing are located in the general library. Students have access to the total library holdings. Library resources are budgeted for annually and to date there has been adequate budget for required resources. Red Deer College has currently received an additional grant to upgrade the entire library holdings and all departments, including nursing are expanding their holdings.	The nursing department has and uses a good supply of audio-visual aids. Students may arrange for individual use of any teaching aids and equipment desired. There are Learning Resource Centre (library) staff and an audio-visual technician available for assistance to instructors and students as necessary.	Publications by Moyra Allen, Jean Mackie, Marguerite Schumacher, Margaret Seymour. A follow-up study of graduates of the program over three classes, as evaluated by the graduates and their employers. Completion anticipated in 1975.	No formal ceremony is held. Under consideration for a general commencement exercise for college. Graduating class holds a social event – banquet and dance. Up to them for planning and financing and faculty are invited.

	F. CREDENTIALLING	
	Registration Examinations (including pass score)	Registration (with A.A.R.N.)
GRANT MacEWAN COLLEGE	Students write the Provincial Registration Examinations at the end of the program. The pass score in Alberta is 350. A total of 93.4% of the 60 graduates writing the exams in 1974 passed at the first sitting. In all five subjects, the class mean was above 500 for a least 60-65% of the graduates.	The graduates are eligible for registration with the A.A.R.N. once they have been successful with the registration examination.
LETHBRIDGE COLLEGE	CNA Conjoint Examinations	Following success on the examinations.
MEDICINE HAT COLLEGE	Students write the Provincial registration examinations at the end of the program. Pass score in Alberta is 350. A total of 52.9% of the 34 graduates writing the examination in 1974 passed at the first sitting. This was considerably lower than in the past two years. There were failures in all subjects for the first time.	Graduates are eligible for registration with the A.A.R.N. once they have been successful in the registration examinations.
MOUNT ROYAL COLLEGE	Pass score of 350	Yes.
RED DEER COLLEGE	Students sit the CNATS nurse registration examinations on completion of their program. The results are standardized scores and pass is 350 with a national mean of approximately 500.	Graduates, on completion of the program, and after passing the nurse registration examinations are eligible for registration with the A.A.R.N. thus becoming a "registered nurse".

	A. CURRICULUM		DIPLOMA PROGRAMS — HOSPITALS		
	Length	Level of Preparation	Nursing Role Being Prepared	Transferability of Credit	Courses Being Shared With Students in Other Disciplines
FOOTHILLS HOSPITAL	132 weeks	Diploma in Nursing — eligible for registration	Prepared to give total patient care using the nursing process to a group of patients. Additional preparation in the theory and practice of leadership skills with experience up to the team leader level.	Between Nursing Programs, transferability is determined on an individual basis. To Baccalaureate Program (U. of A.) transfer is made on basis of basic program completed. Other educational programs (post-secondary non-nursing) 4 - ½ credit courses.	Yes — six courses
GALT SCHOOL OF NURSING LETHBRIDGE MUNICIPAL HOSPITAL	132 weeks	Diploma · eligible for registration	R.N.		
HOLY CROSS HOSPITAL	129 weeks	Diploma — eligible for registration	Function at the staff member level in primary nursing care. Some exposure in specialty nursing units such as Case Room, Intensive Care, Emergency. Minimal team leading experience.	Courses in Psychology 205 and Sociology 201 at the University of Calgary with full university credit for these courses. No other transferability.	Psychology and Sociology at the University of Calgary Campus, only.
MISERICORDIA HOSPITAL	134 weeks	Diploma in Nursing — eligible for registration	Beginning practitioner as a general staff nurse in hospitals and health agencies.	Yes, between other diploma nursing programs. Student assessed on an individual basis. May proceed to post-basic baccalaureate programs after passing R.N. examinations.	None
ROYAL ALEXANDRA HOSPITAL	140 weeks	Diploma in Nursing — eligible for registration	Prepared to function at a beginning staff nurse position providing total patient care; has developed management skills in organizing direct patient care at a beginning staff nurse level position, as well as additional preparation in leadership skills. Students are provided with a six week experience in team leadership and unit management.	Between Diploma Nursing Programs — assessment on an individual basis; B.Sc. Nursing Program (Post-Basic) (University of Alberta) — by program (not specific courses).	
U. OF A. HOSPITAL	112 weeks	Diploma in Nursing — eligible for registration	The new graduate will be prepared to apply a problem solving approach in giving nursing care to individuals of all age groups who have a variety of common health problems. She will also be prepared to participate in the preventative, curative, and restorative aspects of patient care by teaching patients and their families and assisting in their rehabilitation. She will be able to give care which considers the stresses which illness and hospitalization create for the individual. She will be prepared to develop an increasing awareness of her responsibilities and a realization of her potential as a member of a profession and a citizen.	Between nursing programs — assessment on individual basis. To Baccalaureate Nursing Program (Alberta) transferability to post-basic programs. Other non-nursing programs — two half courses (University level).	Two half courses — University level — Psychology 260 and Sociology 371.

	B. TEACHING ARRANGEMENTS General Education Courses	Nursing Courses Theory	 Laboratory	Nursing Practice	Instructor Student Ratio
FOOTHILLS HOSPITAL	All general education courses are taught by professors from the University of Calgary * Sociology 201 35 hours Dept. of Sociology * Sociology 371 35 " " " " * Psychology 205 35 " " " Psychology * Psychology 351 35 " " " " Anatomy & Physiology 90 " Faculty of Medicine – Dept. of Morphological Sciences & Dept. of Physiology Nursing Pharmacology 35 " Dept. of Pharmacology TOTAL 245 * ½ credit granted by U. of C.	500 hours	120 hours	3,200 hours	Overall 1:12 First year 1:10 Second year 1:10 Third year 1:17
GALT SCHOOL OF NURSING LETHBRIDGE MUNICIPAL HOSPITAL	Anatomy and Physiology, Micro., Pharm., Nutrition – Home School Introductory Psychology – U. of L. off-campus credit course. Introductory Sociology – U. of L. off-campus credit course.	1,141 hours	44 hours	2,377 hours	First year 1:8-9 Second year 1:6-8 Third year 1:15-16
HOLY CROSS HOSPITAL	All except Psychology and Sociology taught by School. No English, Physical Education or Elective. First year courses in Communications and Interviewing contracted with the University of Calgary personnel on "extracurricular" basis.	Shared equally by all nursing instructors. The theory is allocated to instructors who specialize in a specific area, e.g. gastronintestinal, cardio-vascular, etc., but laboratory is allocated equally to all instructors regardless of theory specialization.		Supervised by the instructors who teach in the nursing courses.	First year 1:12-15 Second year 1:4-8 Third year 1:3-6
MISERICORDIA HOSPITAL	Anatomy & Physiology Sociology Psychology } Taught by nurse educators. Microbiology Pharmacology Nutrition } Integrated into nursing courses.	901 hours	124 hours	3,221 hours	First year 1:10 Second year 1:14 Third year 1:9-10
ROYAL ALEXANDRA HOSPITAL	Anatomy & Physiology 100 hours Microbiology 39 " Pharmacology 40 " Communications 19 " } Taught by Nurse-Faculty members. Psychology 38 " Sociology 38 " } Contracted-Professors from the appropriate depts. at U. of A. Nutrition Community Health } Integrated throughout total program.	656 hours	66 hours	2,726 hours	Average ratio 1:8-10
U. OF A. HOSPITAL	All nursing courses taught by qualified nursing instructors. Use is made of qualified resource personnel. University personnel are contracted to teach the Sociology and Psychology course Psychology 260 36 hrs. Sociology 371 36 hrs. } (credit) Integration of Nutrition, Pharmacology, Community Health into all courses.	488 hours	502 hours	2,322 hours	Average ratio 1:12

	C. CLINICAL RESOURCES How Obtained: Where or What Outside Sources.	Commitment (specific schedule, specific units, etc.) Arrangements, Contracts.	Extent They Meet the Educational Objectives. Quality of Experience.
FOOTHILLS HOSPITAL	By dialogue with Nursing Service Department of Hospital, community agencies & directors of rural hospitals.	First and second year students are supernumerary, however, nursing units to which these students are assigned are always notified prior to commencement of nursing practice & further notified if changes are made in placement or numbers of students expected. Third year students are considered as part of the nursing team & are rotated through the various shifts & days of the work week as are the other members of the nursing team. Student rotation is planned by the nursing instructor in concert with the Head Nurse.	Clinical experiences are selected for all students on the basis of the objectives to be met. It is felt that the objectives are well met by the available clinical resources.
GALT SCHOOL OF NURSING LETHBRIDGE MUNICIPAL HOSPITAL	Lethbridge Municipal Hospital Community Resources.- City Health Unit Doctors' offices Children's Hospital, Calgary Lethbridge School District V.O.N. Alberta Hospital, Ponoka	No service commitment in 1st year. No service commitment in specialties. 2nd year – except for Med-Surg. Unit Assistant assignment. 3rd year – school takes 2 UNIT NURSE (Med-Surg.) Assignments as completely as possible, and helps fill 9 unit assistant assignment on Med-Surg.	We are satisfied, and particularly pleased with the opportunity for practice in 3rd year in such areas as Emergency, Caseroom, and Psychiatry.
HOLY CROSS HOSPITAL	"Informal" agreement with "home" hospitals – but formal contractual basis and strict adherance to terms of agreement. Formal agreement with Alberta Children's Hospital for pediatric experience. Letters of agreement with various community health agencies for specific one or two day field experiences	All agreements require strict adherence. In "home" hospital, it is agreed that during practicum, all Fridays are set aside for instructor activity in the School as may be required but no other day may be utilized therefore.	In direct ratio with the quantity of instructor supervision. The field experiences (1 or 2 days) are at the appreciation level only.
MISERICORDIA HOSPITAL	Clinical resources Misericordia Hospital. One week at Glenrose Rehabilitation Hospital. One week at Henwood Drug & Alcohol Abuse Center. Field trips to other health care agencies.	Students in first and second year are supernumerary. In the third year there is some service commitment but in general students choose areas for additional elective experience.	Good experience which meets educational objectives in preparing a beginning practitioner to function in an acute care hospital. Little or no experience available for neuro-surgery, renal dialysis, heart surgery or other highly specialized areas.
ROYAL ALEXANDRA HOSPITAL	The School of Nursing uses the Royal Alexandra Hospital as its primary source for clinical experience. Community agencies are also used to enrich the scope of the student program.	Access to clinical facilities within the hospital is gained through discussion with the personnel responsible for nursing service. Facilities are utilized on an on-going basis with staffing of the areas being done "around the service contribution" of the individual program. Our student program is priority in selection of learning experiences.	Because of the size and variety of clinical areas, we have few problems in achieving clinical resources which meet program needs.
U. OF A. HOSPITAL	Use of appropriate units at the University of Alberta Hospital. Integral part of the program. Use of community agencies appropriate to the particular course.	Clinical facilities at the University of Alberta Hospital commited to the School of Nursing. Other agencies are contracted with on an annual basis. Facilities at the University of Alberta Hospital also shared with B.Sc. Nursing Program and other programs.	All facilities are adequate to meet the educational objectives specified by the program. Close interaction with nursing service achieves good working environment.

	D. ADMINISTRATION Entrance Requirements	Selection Procedures	Withdrawal Policies	Budget	Faculty Employment and Tenure Policies	Educational Preparation of Faculty. Number and Levels	Costs, Fees
FOOTHILLS HOSPITAL	Academic — 60% High School Average. Must have: English 30 Chemistry 30 Biology 30 Two additional Academic subjects.	Admissions Committee receives each applicant's file. Acceptance is on basis of Committee agreement, based on academic achievement, health, MMPI, Cornell, interview and references.	Interview with Director; indicate in writing to Director.	3 budgets submitted annually: Capital equipment Operating budget Personnel budget.	No tenure — employed for 12 months. Interviewed annually.	B.Sc. in nursing is minimum.	Entrance fee — $300.00, additional costs approximately $600.00
GALT SCHOOL OF NURSING LETHBRIDGE MUNICIPAL HOSPITAL	100 High School Credits. 50% or higher in: English 30 Two Grade XII Sciences (one must be Biology 30) Two additional Academic subjects. Must obtain an average of 60% or higher.	Admissions Committee Interview — C.P.I. 3 references. School reserves right to select candidates who appear to have the best qualifications.	Notice of resignation is required, stating reasons, including interview. Pass mark is 65%. Only one supplemental exam may be written in either term of first year, or of the 4 final exams in second year. Satisfactory and safe performance is essential.	Separate for School Separate for School Residence. (Does not include maintenance, utilities, as direct cost).	Salaries in A.A.R.N. contract. Educational leave equal to half the time spent in a course.	All have had nursing and teaching experience. Most with a minimum of B.Sc.	1st year — $190.00 2nd year — $125.00 3rd year — $125.00 Library fee — $15.00 Student association $15.00 per year
HOLY CROSS HOSPITAL	Determined by the Faculty relative to the demands of the curriculum. Basically, senior matriculation.	Determined by the Faculty in accordance with criteria required for success in the program. One of the main selection tools is the high school academic record which has become very difficult to assess with the loss of grade 12 departmental examinations.	Determined by the Faculty in accordance with promotion policies again established by the Faculty on the basis of collected data as related to School success/ failure rates and R.N. examinations success/failure rates.	Submitted on annual basis for both capital & operating budget. Final allocation is related to the global budget & the budgetary needs of the hospitals obtaining funds from the same sources.	The Faculty have obtained certification and are currently reviewing their contract.	13 Faculty, with all but 2 at B.Sc. level. The remaining two are one or two courses short of the B.Sc.	
MISERICORDIA HOSPITAL	50% in the following Grade XII subjects: English 30 Biology 30 Chemistry 30 Two additional Academic subjects. Overall average of 60%. High School Diploma — 100 credits.	These are based on academic qualifications, personal interview, state of health and student references.	Based on academic and clinical performance. The school has criteria for academic promotion and these are spelled out in the student guide book. Students who withdraw for health or personal resons may re-enter and complete the program.	Part of the hospital's global budget & is determined in same manner as budget for other hospital departments & in consultation with the Director of the School of Nursing.	Faculty belong to Staff Nurses' Assoc. & policies are determined by the agreement signed by the Hospital and the Staff Nurses' Association.	Faculty consists of a Director, Curriculum Co-ordinator and 17 instructors. All but two instructors are prepared to baccalaureate level and some have additional courses in education or administration.	Approximately $925 for three years. This includes tuition, books, registration, students' union and special clothing items.
ROYAL ALEXANDRA HOSPITAL	Senior matriculation with 100 credits, at least 50% or higher standing in 5 Grade XII subjects: English 30 Biology 30 Chemistry 30 Two additional Academic subjects.	Selection of the class is done by Selections Committee made up of Director — Nursing Education, Assistant Director — Nursing Education & 4 faculty members. Selection based on admission requirements (Primarily health, references & academic standing).		School of Nursing submits a budget request for personnel, capital equipment and operating costs. This is considered along with the total hospital budget.	Policy to employ instructors who possess a baccalaureate degree combined with teaching competence, knowledge of curriculum planning.	Bachelors degree 28 Registered nurse 2	Application fee $5.00 1st year — $230.00 2nd year — $175.00 3rd year — $100.00
U. OF A. HOSPITAL	Senior matriculation — minimum average in 5 30 level courses 60%. High School Diploma — 100 credits. English 30 Chemistry 30 Biology 30 Two additional subjects.	Standard application form. Reference letters. Medical clearance. Interview. Final decision by a Committee on Admissions. Students may be requested to obtain work experience-delayed admission. Use of the University Counselling Service — aptitude testing.	All withdrawals, leaves of absence & dismissals done on an individual basis according to general guidelines. A committee on academic standings involving Faculty members with expertise to make decisions on dismissals. Must write a letter and have an interview before going on leave of absence or withdrawing.	Overall budget is part of U. of A. Hospital budget & is drawn up as a component of the Division of Nursing according to specified services & categories.	Employment is governed by a negotiated contract which is part of overall U. of A. Hospital contract negotiations. No tenure policies exist.	34 full time faculty positions teaching at all levels in the program. All possess clinical experience and can function in a clinical setting. 31 possess B.Sc. qualifications. 2 possess University Diploma certificate and one possesses midwifery training with experience.	Tuition $500.00 (for 30 months) Personal expenses vary (books, graduation and other expenses).

	E. SUPPORT SERVICES Recruitment, Enrollment & Registration	Library Management - Extent of Holdings, etc.	Audio – Visual Aids	Research (curriculum, students, etc.)	Graduation ceremony
FOOTHILLS HOSPITAL	One full-time registrar Open house for high school students – no recruitment. 130 enrolled each year, enter in September.	One full-time Assistant Librarian plus a part-time assistant. 2600 volumes, periodicals – 30 13 audio-visual machines.	Cassettes – 35 programs Film strips & cassettes – 28 programs Film loops – 20 programs Film strips – 10 programs Records – 4 Slides – 32 programs Transparencies – 4 programs Video tapes – 15 programs 16 mm films – 12 8 mm films 5	Survey carried out each year on graduates of school. Survey on all graduates to determine work patterns since graduation.	Graduation for all students of Foothills Hospital June – pins given. Diplomas mailed following R.N. results.
GALT SCHOOL OF NURSING LETHBRIDGE MUNICIPAL HOSPITAL	Done by School, plus U. of L.	Managed by Faculty Committee at present & School Secretary Holdings – books – 1500, journals – 40.	Film projectors, film loop, projector loop, cassette recorders – cassettes, models, charts, slide and strip projector, overhead projector, book plate projector.	None	June each year. Provide pins, reception, dance. Diplomas held until C.N.A.T.S. passed.
HOLY CROSS HOSPITAL	The School provides all support services student enrollment, library. A full-time registrar reports to the Director, who is responsible for policy formulation and exercise.	A full-time Library Assistant reports to the Director, who is responsible for policy formulation and exercise and the physical facilities and holdings of the area.	Falls under the purview of the library.	Primarily the responsibility of the Director. Some curriculum data being gathered but to date have not been analyzed.	Formal Commencement Exercises held at the Jubilee Auditorium. Falls under the responsibility of the Director.
MISERICORDIA HOSPITAL	This is done by the director and faculty and a secretary. No recruitment program.	The Weinlos Library is housed in the hospital, which contains medical & nursing textbooks, as well as a wide selection of periodicals. A library committee, with representatives from several hospital departments, including Nursing Education, directs the activities of the qualified librarian who is in charge of the library.	Charts and models. Equipment for individual practice.	None	A graduation ceremony paid for by the hospital is held at the end of June each year. This is a combined graduation for students in nursing, radiology and laboratory technicians.
ROYAL ALEXANDRA HOSPITAL	The School of Nursing employs a full-time registrar to carry out recruitment and initial screening of applicants. Annual open house is held for applicants. Enrollment of 120 students each September.	One full-time Librarian. Students have access to audio-visual holdings in the library during library hours. Holdings include approximately 200 bound nursing volumes, 35 nursing periodicals, 100 audio-visual. In addition, students have access to the medical library.	See under library.	None	The students participate in a convocation ceremony held at the Jubilee Auditorium & sponsored by Board of Governors. Pins given. They sponsor & support (financially) banquet & dance with parents as quests the evening following the convocation ceremony.
U. OF A. HOSPITAL	All performed directly within the School of Nursing by the Registrar's Office which includes 2 faculty members who make decisions accordingly & one secretary who performs the clerical functions.	One full-time experienced Librarian. Relief employed as needed. Holdings – 2000 books, 25 periodicals, filmstrips, overhead transparencies, 16 mm. films, slides, audiotapes. Average circulation per month 1600. Students have a U. of A. library card and may use all of the campus library facilities. Instructors have individual office libraries.	Holdings include film strips, slides, overhead transparencies, audiotapes, videotapes, 16mm. films related to general and specific areas of the programs. Use of the Health Sciences Audio-Visual Education resources, U. of A.	Developmental work done related to: Curriculum design Instructional procedures Evaluation and assessment Observation & organization of Learning experience Structuring of item bank.	Formal ceremonies sponsored by the institution for each class enrolled.

F. CREDENTIALLING

	Registration examinations (including pass score)	Registration (with A.A.R.N.)
FOOTHILLS HOSPITAL	Pass score – 350 Failure rate – 2.8%	All eligible who pass R.N.'s
GALT SCHOOL OF NURSING LETHBRIDGE MUNICIPAL HOSPITAL		
HOLY CROSS HOSPITAL	R.N. examinations will be written in June, 1975. This is in accordance with the new permission granted by Professional Examinations. Passing score – 350.	Concurrent with graduation
MISERICORDIA HOSPITAL	Students write R.N. examinations, according to regulations of the Professional Examination Office, University of Alberta. The pass mark for this province is 350.	Yes
ROYAL ALEXANDRA HOSPITAL	Pass score of 350 Average 1974: Medical Nursing - 581.70, rank 2; Surgical-Nursing – 597.70, rank 2; Obstetric Nursing – 609.30, rank 1; Nursing of Children – 630.90, rank 1; Psychiatric Nursing – 617.20, rank 1	
U. OF A. HOSPITAL	CNA testing service, same exam as that written by every student in Canada. Pass mark of 350 on each of 5 subject exams.	Upon successful performance on the registered exams.

BACCALAUREATE PROGRAM FOR HIGH SCHOOL GRADUATES

THE UNIVERSITY OF ALBERTA

The University academic year begins in early September and ends with the completion of final examinations at the end of April each year. In addition, the first three years of the nursing program will include the month of May spent in clinical practice followed by three months' vacation.

Candidates for the degree of Bachelor of Science in Nursing will be eligible to write the registration examinations required by the Alberta Association of Registered Nurses.

First Year

September — April

English 200 or 210 or approved Arts option: *e.g.* Art, Classics, History, Political Science, Music, Languages, Psychology.
Sociology 202.
Psychology 260 and 237 or 241 or 283.
Physiology 261 or 262.
Bacteriology 233 (one term).
Nursing 211 — Human Anatomy (one term).
Nursing 232 and 234 — Fundamentals of Nursing: includes lectures, conferences and clinical experience.

May

Nursing 200 — Fundamentals of Nursing Practicum.

Second Year

September — April

Approved Science: *e.g.* Biology, Math, Chemistry, Physics, Psychology from Science section of Calendar.
Approved Psychology (one term): *e.g.* Family 343.
Nursing 340 — Medical-Surgical Nursing Theory I (one term).
Nursing 345 — Medical-Surgical Nursing Practice I (one term).
Nursing 350 — Maternal and Child Health Theory (one term).
Nursing 355 — Maternal and Child Health Practice (one term).
Nursing 357 — Seminar in Education (one term).

May

Nursing 300 — Maternal and Child Health Practicum.

Third Year

September — April

Approved Option.
Approved Statistics.
Sociology 373 and 374 or approved option.
Nursing 360 — Nursing for Mental Health Theory (one term).
Nursing 365 — Nursing for Mental Health Practice (one term).
Nursing 370 — Medical-Surgical Nursing Theory II (one term).
Nursing 375 — Medical-Surgical Nursing Practice II (one term).

May

Nursing 400 — Medical-Surgical and Mental Health Nursing Practicum.

Fourth Year

September — April

Approved Senior Option.
Approved Senior Psychology or Sociology (one term).
Nursing 421 — Research Methods in Nursing.
Nursing 423 — Professional Nursing Trends.
Nursing 441 — Community Health I.
Nursing 443 — Community Health II.
Nursing 445 — Community Health Practice (one term).
Nursing 457 — Process of Developing Education Programs (one term).
Nursing 463 — Patient Care Management (one term).

THE UNIVERSITY OF CALGARY

Year	Session	Courses in the Biological Sciences	Courses in the Social and Behavioural Sciences	Required Courses in Nursing	Additional Courses
I	Fall	Anatomy 261 PHED Biology 201 (or see Biology dept. Exemption ruling)	Sociology 201	Nursing 201 Nursing in Society	Junior English Option (200 level)
	Winter	Microbiology 241 (or see Biology dept. Exemption ruling)	Psychology 205	Nursing 203 Introduction to the Nursing Process	Junior English Option (200 level)
	Inter-session 3 weeks			Nursing 204 Introduction to the Nursing Process	
II	Fall	Zoology 370 Physics 221 OR Chemistry 359	Psychology 351	Nursing 301 Family Growth and Development —Part I	Option†
	Winter	Zoology 370 Physics 223 OR Biochemistry 337 or 339	Sociology 371	Nursing 303 Family Growth and Development —Part II	Option †
	Inter-session 3 weeks			Nursing 304 Nursing of Adolescents and Young Adults	
III	Fall		Psychology 353 Psychology 381 Anthropology 391	Nursing 401 Nursing of Adults Part I	Option †
	Winter	Biology 315	Anthropology 491	Nursing 403 Nursing of Adults Part II	Option †
	Inter-session 3 weeks			Nursing 404 Nursing of Multi-Problem Patients, Part I	
IV	Fall	Biology 305 OR Computing Science 201 OR Sr. Biological Science Option	Social Science Option	Nursing 512 Nursing of Multi-Problem Patients, Part II Nursing 514 Issues and Problems in Nursing	Junior Philosophy OR Philosophy 300
	Winter	Psychology 215 Biology 307 OR Computing Science 221 or 225 OR Sr. Biological Science Option		Nursing 512 Nursing of Multi-Problem Patients, Part III Nursing 514 Issues and Problems in Nursing OR Nursing 525 Independent Study in Nursing †† (in Winter Session)	Junior Philosophy OR Philosophy 300

† Options are to be selected from Arts and Science Area I; from the following subjects in Arts and Science Area II: Archaeology, Economics, Geography, History or Political Science, from Fine Arts, and from the ungrouped courses of Pure and Applied Mathematics and Interdisciplinary Studies. The minimum requirement in each of the selected option subjects is one junior level half course and one senior half course; OR a senior level half course which has no junior course prerequisite; OR a senior level full course.

†† The Independent Study in Nursing is designed for those students with 3.0 grade point average or better, in nursing content courses, and with nursing faculty approval.

COUNCIL ON ADMISSIONS AND TRANSFER: TERMS OF REFERENCE

The following Terms of Reference were adopted by Council motion on February 14, 1975:

1. The Council shall review current regulations, proposals and practices for admissions and transfer which have been generated by Advanced Education and by institutions and subsystems for the purpose of identifying those guidelines and procedures applicable to all institutions within the system of advanced education.

2. The Council shall develop procedures by which admissions and transfer policies, guidelines and procedures are granted system-wide approval.

3. The Council shall compile, maintain and disseminate a registry of all existing admissions and transfer arrangements within the Alberta system of advanced education.

4. The Council shall monitor the effectiveness of admissions and transfer policies and practices throughout the advanced education system; to this end it may carry out, or request institutions to carry out appropriate studies.

5. The Council shall recommend to Advanced Education and to institutions revisions of policies, guidelines and procedures as it deems necessary.

6. Acting within the provisions of existing legislation, the Council shall upon the written request of an institution, serve as mediator in resolving interinstitutional admission and transfer problems. (The Council will not deal with requests by individuals).

7. In the event that agreement cannot be reached through mediation, the Council shall upon written request by the institutions concerned, serve as arbitrator.

8. In fulfilling its arbitration role, the Council shall establish arbitration procedures, inform the institutions of these procedures, and inform the institutions of its decisions, which shall be final and binding.

9. The Council shall advise the Minister of any legislative changes which it deems necessary.

10. The Council, at the request of the Minister or institutions, shall comment on unresolved transfer problems related to proposed programs.

11. The Council shall report annually to the Minister of Advanced Education on its activities.

12. The Council will operate with the support of:

    (a) Council members to be reimbursed by Advanced Education for out-of-pocket expenses incurred;

    (b) the Chairman to be paid an appropriate honorarium; and

    (c) an executive secretary and such other necessary resources and services to be made available by Advanced Education as required by the Council in the fulfillment of its responsibilities.

SOURCE: Council on Admissions and Transfer, February, 1975.

ANA STANDARDS OF NURSING PRACTICE

Standard I

THE COLLECTION OF DATA ABOUT THE HEALTH STATUS OF THE CLIENT/PATIENT IS SYSTEMATIC AND CONTINUOUS. THE DATA ARE ACCESSIBLE COMMUNICATED, AND RECORDED.

Rationale: Comprehensive care requires complete and ongoing collection of data about the client/patient to determine the nursing care needs of the client/patient. All health status data about the client/patient must be available for all members of the health care team.

Assessment Factors:

1. Health status data include:
   - Growth and development
   - Biophysical status
   - Emotional status
   - Cultural, religious, socioeconomic background
   - Performance of activities of daily living
   - Patterns of coping
   - Interaction patterns
   - Client's/Patient's perception of and satisfaction with his health status
   - Client/patient health goals
   - Environment (physical, social, emotional, ecological)
   - Available and accessible human and material resources

2. Data are collected from:
   - Client/Patient, family, significant others
   - Health care personnel
   - Individuals within the immediate environment and/or the community

3. Data are obtained by:
   - Interview
   - Examination
   - Observation
   - Reading records, reports, etc.

4. There is a format for the collection of data which:
   - Provides for a systematic collection of data
   - Facilitates the completeness of data collection

5. Continuous collection of data is evident:
   - Frequent updating
   - Recording of changes in health status

6. The data are:
   - Accessible on the client/patient records
   - Retrievable from record-keeping systems
   - Confidential when appropriate

Standard II

NURSING DIAGNOSES ARE DERIVED FROM HEALTH STATUS DATA.

Rationale: The health status of the client/patient is the basis for determining the nursing care needs. The data are analyzed and compared to norms when possible.

Assessment Factors:

1. The client's/patient's health status is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of deviation.

2. The client's/patient's capabilities and limitations are identified.

3. The nursing diagnoses are related to and congruent with the diagnoses of all other professionals caring for the client/patient.

Standard III

THE PLAN OF NURSING CARE INCLUDES GOALS DERIVED FROM THE NURSING DIAGNOSES.

Rationale: The determination of the results to be achieved is an essential part of planning care.

Assessment Factors:

1. Goals are mutually set with the client/patient and pertinent others:
   - They are congruent with other planned therapies.
   - They are stated in realistic and measurable terms.
   - They are assigned a time period for achievement.

2. Goals are established to maximize functional capabilities and are congruent with:
   - Growth and development
   - Biophysical status
   - Behavioral patterns
   - Human and material resources

Standard IV

THE PLAN OF NURSING CARE INCLUDES PRIORITIES AND THE PRESCRIBED NURSING APPROACHES OR MEASURES TO ACHIEVE THE GOALS DERIVED FROM THE NURSING DIAGNOSES.

Rationale: Nursing actions are planned to promote, maintain and restore the client's/patient's well-being.

Assessment Factors:

1. Physiological measures are planned to manage (prevent or control) specific patient problems and are related to the nursing diagnoses and goals of care, *e.g.* ADL, use of self-help devices, etc.

2. Psychosocial measures are specific to the client's/patient's nursing care problem and to the nursing care goals, *e.g.* techniques to control aggression, motivation.

3. Teaching-learning principles are incorporated into the plan of care and objectives for learning stated in behavioral terms, *e.g.* specification of content for learner's level, reinforcement, readiness, etc.

4. Approaches are planned to provide for a therapeutic environment:
   - Physical environmental factors are used to influence the therapeutic environment, *e.g.* control of noise, control of temperature, etc.
   - Psychosocial measures are used to structure the environment for therapeutic ends, *e.g.* paternal participation in all phases of the maternity experience.
   - Group behaviors are used to structure interaction and influence the therapeutic environment, *e.g.* conformity, ethos, territorial rights, locomotion, etc.

5. Approaches are specified for orientation of the client/patient to:
   - New roles and relationships
   - Relevant health (human and material) resources
   - Modifications in plan of nursing care
   - Relationship of modifications in nursing care plan to the total care plan

6. The plan of nursing care includes the utilization of available and appropriate resources:
   - Human resources – other personnel
   - Material resources
   - Community

7. The plan includes an ordered sequence of nursing actions.

8. Nursing approaches are planned on the basis of current scientific knowledge.

Standard V

NURSING ACTIONS PROVIDE FOR CLIENT/PATIENT PARTICIPATION IN HEALTH PROMOTION, MAINTENANCE AND RESTORATION.

Rationale: The client/patient and family are continually involved in nursing care.

Assessment Factors:

1. The client/patient and family are kept informed about:
   - Current health status
   - Changes in health status
   - Total health care plan
   - Nursing care plan
   - Roles of health care personnel
   - Health care resources

2. The client/patient and family are provided with the information needed to make decisions and choices about:
   - Promoting, maintaining and restoring health
   - Seeking and utilizing appropriate care personnel
   - Maintaining and using health care resources

Standard VI

NURSING ACTIONS ASSIST THE CLIENT/PATIENT TO MAXIMIZE HIS HEALTH CAPABILITIES.

Rationale: Nursing actions are designed to promote, maintain and restore health.

Assessment Factors:

1. Nursing actions:
   - Are consistent with the plan of care
   - Are based on scientific principles
   - Are individualized to the specific situation
   - Are used to provide a safe and therapeutic environment
   - Employ teaching-learning opportunities for the client/patient
   - Include utilization of appropriate resources

2. Nursing actions are directed by the client's/patient's physical, physiological, psychological and social behavior associated with:
   - Ingestion of food, fluid and nutrients
   - Elimination of body wastes and excesses in fluid
   - Locomotion and exercise
   - Regulatory mechanisms – body heat, metabolism
   - Relating to others
   - Self-actualization

Standard VII

THE CLIENT'S/PATIENT'S PROGRESS OR LACK OF PROGRESS TOWARD GOAL ACHIEVEMENT IS DETERMINED BY THE CLIENT/PATIENT AND THE NURSE.

Rationale: The quality of nursing care depends upon comprehensive and intelligent determination of nursing's impact upon the health status of the client/patient. The client/patient is an essential part of this determination.

Assessment Factors:

1. Current data about the client/patient are used to measure his progress toward goal achievement.

2. Nursing actions are analyzed for the effectiveness in the goal achievement of the client/patient.

3. The client/patient evaluates nursing actions and goal achievement.

4. Provision is made for nursing follow-up of a particular client/patient to determine the long-term effects of nursing care.

Standard VIII

THE CLIENT'S/PATIENT'S PROGRESS OR LACK OF PROGRESS TOWARD GOAL ACHIEVEMENT DIRECTS REASSESSMENT, REORDERING OF PRIORITIES, NEW GOAL SETTING AND REVISION OF THE PLAN OF NURSING CARE.

Rationale: The nursing process remains the same, but the imput of new information may dictate new or revised approaches.

Assessment Factors:

1. Reassessment is directed by goal achievement or lack of goal achievement.
2. New priorities and goals are determined and additional nursing approaches are prescribed appropriately.
3. New nursing actions are accurately and appropriately initiated.

SOURCE: *The American Nurse,* Kansas City, Missouri, July, 1974: 1–4.

THREE MAJOR TYPES OF JOINT APPOINTMENTS DEVELOPED AT FRANCES PAYNE BOLTON SCHOOL OF NURSING, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OHIO

SHARED APPOINTMENT involves shared cost as well as shared responsibility for education and service. The joint appointment may be known as chairperson/director, faculty-nurse clinician, and so on. The extent of sharing is determined by the needs of the two organizations. The shared appointment must be viewed as one job, and reasonable expectations should be set by the role encumbent and held by others to prevent role overload, role conflict, and role ambiguity.

The secret for the chairperson/director is to have a cadre of competent associates in each organization to whom she can delegate responsibility for day-to-day operations. For the encumbent of the faculty-clinician role, it is important to have had some experience in both and be helped to set reasonable expectations by the chairperson/director.

CLINICAL APPOINTMENT – or a "leadership-clinical" appointment – is that held by other leaders in nursing service who are paid fully by the service agency and have their primary responsibility there. Their major contribution to the education of students is to ensure that the quality of care provided to patients is that desired for students to observe and emulate, and to ensure that attitudes toward students are supportive and helpful.

Other involvement in learning opportunities provided students varies with the individual and the situation. The privileges of the clinical appointment include participation in general and clinical faculty meetings, gaining knowledge of and contributing to curriculum development, serving on committees, and participating in educational and social activities for the faculty.

ASSOCIATE APPOINTMENT is given to all faculty who guide students in practice of research in the clinical setting. It has been formalized only in the hospital, but some of the privileges and responsibilities apply in other agencies used for student practice. The major responsibility is to influence the quality of care and attitudes of staff in the agency to promote an exemplary learning climate. The privileges afforded are for practice and research, and include participation on committees and in work groups that are designed to enhance care.

SOURCE: MacPhail, J. "Promoting Collaboration Between Education and Service," *Canadian Nurse*, 71, May, 1975:33.

EXCERPTS FROM NATIONAL LEAGUE OF NURSING, ARRANGEMENTS BETWEEN AN INSTITUTION OF HIGHER EDUCATION AND AGENCIES WHICH PROVIDE LEARNING LABORATORIES FOR NURSING EDUCATION, 1972

IV. The Faculty-student group from the college makes substantial and valuable contributions to nursing service in the course of the education. The students under faculty guidance and supervision provide excellent care for assigned patients. Thus agency nursing staff members are relieved of this care and to some extent of direct supervisory responsibility.

A. The instructor is responsible to the head nurse or supervisor of the unit for the quality of care her students provide.

B. She is also responsible for her own and her students' "fitting into" the organization, relationships, and activities of the agency so that their joint contribution will be of real value and students will be well prepared in this respect as graduates.

1. She is responsible for thoroughly familiarizing herself with the policies, standards, nursing procedures, and physical setup of the unit and for establishing friendly relationships with personnel before students arrive. The best method is for her to work there for a period in the capacity of staff nurse and for the agency to give her effective orientation.

2. She is responsible for orienting the students to the situation and for teaching them the proper attitudes, relationships, and procedures for a member of the unit. For example, the students are directly responsible to her for their care of patients, but they are also responsible to the head nurse like other nursing personnel and are taught to report to her before leaving the unit.

3. She also contributes in every way possible, in accordance with the wishes of the staff, to conferences in which her point of view and knowledge of recent developments in her field may have value. Indirectly, through her teaching of students, or directly, she may make valuable contribution to in-service education.

4. The faculty-student group of the college and the education in which they are engaged are often a source of great interest and stimulus to members of the staff, according to the testimony of many agencies that are cooperating in this kind of association. The fact that this education is going on in the agency reportedly attracts personnel alert to opportunities for self-improvement.

V. The fundamental mutual responsibility of the college faculty in nursing and the staff of the agency in making the association successful is that of maintaining harmonious, cooperative relationships, with an understanding of each other's primary obligations to education and service, but also in agreement on the common purpose of both — namely, the provision of the best possible nursing care for people. Joint planning is the essential means of satisfaction on both sides.

A. The head of the educational unit in nursing of the college plans well in advance — usually a year ahead — with the director of the agency for the placement of students. The number the agency can accommodate at a given time and the arrangements for them are discussed and agreed upon.

B. A planning conference in which the faculty members and the staff members in the units involved are participants should be held before the faculty-student group comes to the hospital for the first time, and similar conferences should be called periodically when there are changes in personnel or other circumstances that make them advisable.

C. Week-by-week and day-by-day planning of

student assignments by the instructor and the head nurse or supervisor of the unit is indispensable.

D. An evaluation conference, including the instructor, the students, and the members of the nursing staff in the units where practice has taken place, should be held at the conclusion of the practice experience. Frank discussion of values, problems, and methods of improvement on both sides can be a very effective way of uncovering and correcting difficulties and increasing mutual understanding and goodwill.

E. A student's learning experience is enhanced through the participation of nursing staff as resource persons in conferences and discussion groups.

VI. The agency provides facilities, opportunities, favorable conditions, and staff time and cooperation in planning with the faculty.

A. The facilities include conference rooms and space for small reference libraries near clinical situations and offices for instructors. They may also include classroom and central library space. The extent of facilities needed depends on their distance from the campus.

B. The opportunities for clinical instruction are sufficient in extent and variety for satisfactorily inclusive education of the number of students involved, and the best possible facilities for appropriate teaching and learning are made available as instructors indicate specific needs.

C. The conditions important for good education are:

1. An environment of high-quality medical and nursing care in which students learn good attitudes and methods from constant observation, incidental teaching by doctors, nurses, and allied health personnel, as well as by example and from planned instruction. These influences are often far more powerful and enduring than the precepts of a teacher.

2. A climate of friendliness towards the instructor and students and of genuine cooperative interest in their welfare and the success of the educational undertaking in which they and the agency are associated.

VII. This kind of association between college and health agencies ordinarily involves no exchange of money. The association is based on mutual interest in good nursing (education and service), on mutual goodwill, and agreement to exchange what each has to offer while pursuing its own appropriate purposes. The contributions made by the faculty-student group and those made by the agency are thought to balance each other fairly equally. The most important point to be clearly understood on both sides is that the student is receiving high values in her education in the theory and practice of nursing. The payment of tuition, in this as in other types of education, rarely covers the cost to the college, which means that the students benefit from the public or private support given the college for the balance. The values received by the agency are not financial ones, because students whose practice is concentrated on educational purposes do not replace regular staff and cannot be shifted to meet service needs from assignments selected to forward their learning. As one director of nursing put it, "We do not depend on the college students to staff the agency. We can manage without them, but with them we can give much better nursing care, and the faculty and students contribute many other unmeasurable values".

SOURCE: National League for Nursing, *Arrangements Between an Institution of Higher Education and Agencies which Provide Learning Laboratories for Nursing Education.* New York, 1973: 4–8.

AMERICAN NURSES ASSOCIATION'S DEFINITION, ASSUMPTIONS AND GOALS OF CONTINUING EDUCATION

Definition

Continuing Education in nursing consists of planned learning experiences beyond a basic nursing educational program. These experiences are designed to promote the development of knowledge, skills, and attitudes for the enhancement of nursing practice, thus improving health care to the public.

Assumptions

1. All nursing practitioners engage in Continuing Education.

2. Continuing Education is essential for maintaining competence in nursing practice.

3. Continuing Education needs of nursing personnel are affected by many factors, including:

   - changes in health delivery systems with increased participation of nurses in those systems
   - changes in licensure laws
   - increase in number and variety of health personnel with changes in their roles and responsibilities
   - legislative changes which influence health care
   - increased demands for health care
   - greater acceptance of individual accountability and responsibility for practice
   - changes in demographic characteristics (recipient population/provider population)
   - health and nursing research with associated advances in health and nursing science
   - personal growth, professional maturity, and changing career goals of the individual

Goals

In order to implement the goals of Continuing Education, providers of Continuing Education programs in nursing must collaborate with other health professionals, nursing personnel, community agencies, and consumers of health care services in the development of Continuing Education offerings. Continuing Education provides a future orientation by inquiring into and demonstrating means to improve:

- nursing care
- education
- administration
- research
- the health care system

The goals of Continuing Education are to:

1. Communicate, transmit and advance nursing science

2. Maintain flexibility and responsiveness to learning needs of nurses through a variety of sound educational approaches

3. Assess continuously and respond to immediate as well as long range Continuing Education needs of nurses

4. Demonstrate emerging nursing content and competence required to accommodate to changes in the health care delivery system

5. Provide learning opportunities through which practicing nurses attain or increase competence appropriate to their roles

6. Field test nursing knowledge and competence that may later be included in pre-service and/or graduate programs

7. Assess continually and periodically evaluate the effectiveness of program offerings

8. Promote individual responsibility and accountability of nursing personnel for their own continued learning

9. Provide opportunities for the non-practicing nurse to become aware of changes in nursing and health care

SOURCE: American Nurses Association. *Standards for Continuing Education in Nursing.* Kansas City, Missouri, 1974:2–3.

AMERICAN NURSES ASSOCIATION (1974) RESPONSIBILITIES ASSOCIATED WITH CONTINUING EDUCATION: THE ASSOCIATION, THE INDIVIDUAL, THE FACULTY

Responsibilities:

The Association

The American Nurses Association develops standards for nursing education and devises methods for gaining their acceptance and implementation through appropriate channels. The national association carries responsibility to assist the state associations in developing Continuing Education programs.

Each state association has the responsbility to apply universal standards, and to develop a Continuing Education Recognition Program which meets the health care needs of the public and the unique educational needs of nursing personnel. To protect the ease of mobility nurses now enjoy, the recognition program should be compatible with those of other states. State Nurses Associations also have the responsibility to work cooperatively with individuals, organizations, and institutions to:

- assess the needs for, the availability of, and necessity of Continuing Education opportunities
- encourage the development of quality Continuing Education activities throughout the state
- assist in the planning and provision of offerings
- participate in evaluation of programs in terms of changes in nursing practice
- disseminate information about Continuing Education offerings.

The Individual

The ultimate responsibility for Continuing Education rests with the individual to:

- identify one's own Continuing Education needs
- make learning needs known to the appropriate sources
- take the initiative in seeking Continuing Education activities to meet these needs
- share the information obtained from the Continuing Education activities with colleagues
- seek ways to integrate new knowledge and skills in practice
- evaluate these activities

The Faculty

Faculties in schools of nursing have a responsibility to transmit the value of a system of professional nursing to students. Faculty in Continuing Education programs have a responsibility to:

- assess Continuing Education needs and translate needs into organized learning experiences
- design, implement, and evaluate Continuing Education offerings
- collaborate with other professionals in health and related fields in the development of Continuing Education experiences
- establish accurate and retrievable Continuing Education records
- utilize existing research and generate new research in the field of Continuing Education
- actively participate in their own Continuing Education

SOURCE: American Nurses Association. *Standards for Continuing Education in Nursing.* Kansas City, Missouri, 1974: 3–4.

NURSING SERVICES STANDARD V – STAFF DEVELOPMENT PROGRAMMES

There shall be a staff development programme for all categories of nursing personnel, to facilitate the achievement of each person's full potential in nursing.

Interpretation

The staff development programme should be under the direction of a registered nurse who is qualified for the position by education and/or experience. The lines of authority and responsibility for this position should form an integral part of the organization chart of the nursing department.

The staff development programme should be designed to ensure that all nursing personnel have the competency necessary to carry out their assigned functions and/or responsibilities, and to ensure continuous improvement in nursing care.

The philosophy and objectives of the staff development programme should be clearly stated and should be consistent with those of the nursing service. These should be sufficiently broad to provide a framework within which a variety of programmes, to meet specific objectives, may be developed.

The staff development programme should include the following components:

(a) A planned orientation programme for all new nursing employees;
(b) A programme of in-service education;
(c) A programme of continuing education.

The programme should be designed to introduce the individual employee to the new environment and as an orientation to the relationship between the nursing department and the total organization. It should specify particular duties and/or responsibilities, lines of authority and responsibility, and when necessary, provide the appropriate resource materials and/or skill training.

It should provide opportunities for all members of the nursing department to keep their nursing knowledge current and their practices relevant. It should facilitate the development and improvement of skills and inherent leadership potential. It should provide for and encourage the utilization of professional literature and other resource materials. It should facilitate improvements in the patient care delivery system of which nursing is a part. It should encourage and support nursing investigation and research, incorporating the results into the staff development programme.

It should provide staff with information regarding educational opportunities sponsored by institutions other than the employing agency, and encourage and facilitate the participation of staff in such educational opportunities. It should encourage active involvement in professional organizations and/or community endeavours related to health and social well being.

SOURCE: Canadian Council on Hospital Accreditation, *Guide to Hospital Accreditation,* Toronto, 1972:32–33.

NURSING ASSISTANT PREPARATION AND TRAINING

The basic education necessary for admission to a nursing assistant course in Canada is usually successful completion of first or second year in secondary school (nine or ten years of schooling). More than one hundred accredited schools provide courses, usually of ten or twelve months duration. These courses are offered by the provincial departments of health and of education and by individual hospitals and Community Colleges.

On completion of courses, students are eligible to write examinations for certification, licensure, or registration.

General Requirements

The occupation of nursing assistant is regulated by statute in all provinces of Canada except Newfoundland and Quebec.* These statutes require that nursing assistants be certified, registered or licensed before they will be allowed to practise. Legislation may be included in the provincial Nurses' Act (New Brunswick, Ontario and Saskatchewan) or exist as a separate statute (Nova Scotia, Prince Edward Island, Manitoba, Alberta, British Columbia). In most cases the legislation is administered by the provincial Department of Health, frequently represented on a joint accrediting board or council, but in New Brunswick, Ontario and Saskatchewan certification of nursing assistants is carried out by the registering bodies for professional nurses.

The statutory requirements for each province vary but tend to follow a pattern:

- a minimum basic educational attainment of first or second year high school (nine or ten years of schooling);
- successful completion of a ten or twelve-month course in a provincially approved school of training for nursing assistants or in Quebec, the completion of grade 10 and 11 of Secondary School nursing assistant section (option infirmiers (es) auxiliaire);
- passing examination(s) conducted by the certifying body; a minimum age for practice, ranging from 18 in Saskatchewan to 21 in Manitoba.

Most provinces will give at least partial recognition to certification in another province or country, and will give some credit for training or experience outside the province, if that experience is considered to be equivalent.

It is not necessary in any province to be a Canadian citizen in order to practise, and there is no need to have lived in Canada for a specified time before employment as a nursing assistant can be obtained. For employment purposes nursing assistants should be reasonably proficient in either English or French, depending on usage in the area of intended destination.

Requirements by Province

Newfoundland

While there is no statutory control of the occupation, there is some control of the occupation through a Nursing Assistant Advisory Ministerial Committee. This Committee is composed of representatives of the Association of Registered Nurses, the Newfoundland Hospital Association, the Department of Health, representatives of the Hospitals with Schools for Nursing Assistants as well as the College of Trades and Technology.

* Changes in legislation pending.

Nova Scotia

The Nursing Assistants Act provides for a Board of Registration of Nursing Assistants which is responsible for certification of nursing assistants under the general supervision of the Department of Health. Graduation from an approved school of nursing assistants is required. Credit is given for registration or training outside the province at the discretion of the Board. A knowledge of English is required.

New Brunswick

Registered Nursing Assistants are authorized to practise under the Registered Nurses' Act, which is administered by the New Brunswick Association of Registered Nurses. While there are no requirements in the Act regarding age or education, it should be noted that the minimum age to enter a school for nursing assistants is 17 years and the basic education required is the equivalent of nine years in the New Brunswick public school system or grade eight in the New Brunswick public school system with upgrading to grade 10. Graduation from an approved school of nursing assistants, or equivalent training in another province or country, is required to apply for registration.

Prince Edward Island

The Licensed Nursing Assistants Act is administered by the Department of Health. The minimum age for practise is 19, and the basic education required is ten years of schooling. Graduation from a twelve-month course of prescribed curriculum in an approved school is required. Credit is given for graduation from a recognized school of nursing assistants outside the province. The licensure requirements are as follows:

- experience and instruction in psychiatric and geriatric nursing is a requirement for licensure of Nursing Assistants;
- all candidates for licensure as nursing assistants must pass successfully either the Canadian Nurses' Association Testing Service Examinations for Nursing Assistants or the State Board Test Pool Examinations for Practical Nurses in order to be licensed to practise as nursing assistants except those who have registered nurse status;
- all candidates for renewal of registration who have not been practising nursing within the last five years will be required to take a refresher course under the guidance of a nurse educator before a current licence to practise nursing is issued.

Quebec

Since February 1st, 1974, nursing assistants are certified to practise under Article 36 (p, 37), of the Professional Code of the province of Quebec, which is administered by the "Professional Corporation of Nursing Assistants of Quebec".

Ontario

Registered or Certified Nursing Assistants are regulated by the Nurses' Act, which is administered by the College of Nurses of Ontario, the registering authority for nurses in the province. The minimum age required to begin training is 17 and the minimum requirement for admission to a training centre is grade 10 or the standing equivalent as determined by the Minister of Education. If an applicant is 21 years of age or over, the minimum requirement is evidence of successful completion of grade 8 or the standing equivalent as determined by the Minister of Education.

Registration or graduation from an approved school outside Ontario will be considered acceptable by the College if they meet the requirements.

Manitoba

The Licensed Practical Nurses' Act is administered by the provincial Department of Health. The minimum age for practice is 21. Completion of a prescribed course of studies and training at an approved school is normally required. Those with specialized training may get a "special licence" in a particular field.

Saskatchewan

Certified Nursing Assistants are authorized to practise under the Registered Nurses Act, which is administered by the Saskatchewan Registered Nurses Association. The minimum age for certification is 18. Completion of a prescribed course of theory and practice in a school for nursing assistants approved by the Council of the Association is normally required, but satisfactory evidence of competence in another province or country may be recognized by the Council as equivalent.

Alberta

Certified Nursing Aides are authorized to practise under the Nursing Aides Act, which is administered by the Provincial Department of Health. Applicants must be between the ages of 17½ and 55 to qualify for training, and have completed ten years of schooling. The course of study totals approximately ten months and must be taken at an approved institution. Credit for training and experience outside the province may be given at the discretion of the certification council.

British Columbia

Licensed Practical Nurses are accredited under the Practical Nurses' Act, administered by the Council of Practical Nurses under the general supervision of the provincial Department of Health. Completion of a 12-month course in practical nursing at an approved school is normally required. Applicants for admission to provincially operated training schools must be at least 18 years of age, have completed 10 years of education, and have adequate knowledge of the English language. Credit may be given for courses taken outside the province at the discretion of the Council.

SOURCE: Canada. Department of National Health and Welfare. Health Manpower Directorate. *Education and Regulation of Selected Health Occupations in Canada: Nursing Manpower.* Health Manpower Report 7–74. Ottawa, 1974:13–16.

DEVELOPMENTS IN DIPLOMA NURSING PROGRAMS IN CANADA 1964–1974

Major forces at the root of the trend away from the service-oriented pattern of diploma nursing education and toward an educational-centered type of learning were political and economic; secondary forces were social and technical.

A first determinant in the transfer witnessed was the report of a national study ordered by the Government of Canada whereby a commission was charged to inquire into and report upon existing facilities and future needs of health services of the people of Canada. Within the commission's broad mandate, nursing education was included. The Report, referred to in Chapter I as the Hall Report, released in 1964, largely influenced nursing education in Canada. Statements, beliefs and recommendations contained in the report, bold and forceful, contended that nursing education and nursing service should be divorced, their budgets separated and programs shorter than the traditional three year pattern.

In 1964, then, a national governmental commission pressed for a gradual break with the long-standing pattern of diploma nursing education; almost simultaneously a national voluntary nurses association gave impetus for change and reform in the system. Provincial nurses' associations, likewise disenchanted with the type of service-oriented nursing education, became increasingly vocal in pointing out inadequacies in the system. Provincial associations, however, had not the funds nor the authority to effect changes, hence they exerted resolute pressures on provincial governments primarily through the media of submissions, reports and recommendations. Within respective provincial contexts, the transfer resulted either from pressures exerted or activity initiated by the Provincial Nurses Association, the Department of Health or the Department of Education. Change was generally the end result of a cooperative effort of all three.

In the provinces where the transfer is complete, namely Saskatchewan, Ontario and Quebec, the flow of events generally tended to be as follows: the striking of a committee or commission by order-in-council with the responsibility of examining the process of nursing education; the requesting and reviewing of submissions; the preparation and release of a report containing recommendations, the latter not infrequently made firm by legislative enactments or by the issuance of governmental policies, and finally the implementation of the said decision through cooperative efforts on the part of all concerned.

Change in Saskatchewan was the direct result of pressures exerted by the SRNA on the Minister of Health, the establishment of an Ad Hoc Committee on Nursing Education by order-in-council, patterned after the recommendation found in the Hall Report, and subsequent legislative enactments. The province of Saskatchewan showed boldness in that it defied a previous belief with regard to the necessity of first establishing a system wherein nursing education might then be introduced. Changes were legislated before a suitable post-secondary educational institution was available to educate nurses, but the province was rapid to erect such institutions. Thus, the move toward innovation, propelled by political forces, was rapid and relatively free of resistance.

Quebec differed from Saskatchewan in that changes were not the result of action initiated by ONQ nor the Department of Health, but rather were largely the outcome of the study and report of the Royal Commission of Inquiry on Education. Mutations in the long-standing pattern of diploma nursing education may be said to have had for foundation the social and technological revolution which suddenly took place in the province. General education having fallen increasingly short of technological and

societal needs, the Royal Commission recommended a global reshaping of the entire system. Legislative enactments therefore made provisions for the establishment of a Ministry of Education and CEGEP wherein diploma nursing education, being technical in nature, thereafter had a niche. With the passage of the latter Act in 1967, a suitable educational system thus being established, the process of transferring diploma nursing programs was initiated. Economic determinants soon accelerated change in that the Hospital Insurance Commission began to equate nursing education conducted in hospitals against the dollar value destined to meet health care needs. As a result, the Ministry of Health and Hospital Insurance Commission made public their intent to alter a previously held policy with regard to free room and board, and indicated the decision to include tuition fees. Hence, the interplay of social, technical and political forces prompted the transfer of diploma nursing programs to the system of education, but economic forces greatly hastened the process. The Ministry of Education and ONQ actively guided and supervised the process from its inception to its termination.

In Ontario, major determinants which facilitated or culminated in a complete transfer of programs were: first, the legislative enactment and subsequent establishment of CAAT throughout the province; second, the implementation of the Minister of Health's ten year plan, with the reluctant cooperation of the College of Nurses of Ontario, leading to a gradual shortening and regionalization of schools of nursing; third, the study and release of the *Report of the Committee on the Healing Arts* ordered by the Minister of Health; fourth, the announcement of a change of policy with regard to free room and board for nursing students; and finally, a joint policy statement issued by the Minister of Health and the Minister of Colleges and Universities proclaiming a transfer of the fifty-six existing schools of nursing to the system of education effective September 1, 1973. Although CAAT were made more readily accessible by 1967, it is the Minister of Health who initiated activity toward change; later, it was the Minister of Health and the Minister of Colleges and Universities who dictated the course of events bringing the process to term.

In those provinces where the transfer of diploma nursing programs to the system of education is partial, the trend toward a move has generally been promoted by the Nurses Association but activity in this direction has been initiated by individual colleges. This has particularly been the case in British Columbia where external forces tended to direct change independently of any carefully mapped plan of the RNABC. In the province, activity toward the development of a first program was initiated by the Department of Education; the project was realized with the cooperative effort of RNABC. Other colleges then continued in this direction. Recent political activity foretells of future major alterations in the system of diploma nursing education. The *Medical Centre of British Columbia Act* embodying provisions for a Provincial Council with wide ranging powers over health and education will tend to direct diploma nursing programs toward a more central form of control.

While a variety of groups in Alberta continue to come up to conflicting recommendations, the AARN persists in pressuring for a transfer; colleges, on the other hand, seek and in fact obtain authorization to develop basic diploma nursing programs. In Alberta, the stronghold for hospital schools, nursing education has become a political issue; political forces promoting change, persistently paralleled by equally strong opposing forces, are interlocked with pressures to transfer responsibility for the prescription, maintenance and control of standards in nursing education. A recent

stand taken by the Minister of Advanced Education points, although not without resistance, to a future complete alteration of the system of nursing education.

In Manitoba, a governmental committee patterned after the recommendation contained in the Hall Report made recommendations which were in close alignment with recommendations previously formulated by a similar committee in a neighbouring province. Although recommendations in Saskatchewan soon caused the system to topple, this was not the case in Manitoba. Rather, the trend has been to realize internal changes in hospital schools. It was the government which initiated the first and only move to a college setting; this project was achieved cooperatively by the Department of Education, the Department of Health and MARN. Despite an apparent state of quiescence in the province, the MARN contends that ideas enunciated by the governmental committee in 1966 are being revived and political forces point to changes in a foreseeable future.

Forces promoting change, whether political, economic, social or technical in nature, tend to be well documented; counter forces, are less well documented, but literature reveals that forces which fostered change likewise tend to inhibit innovation. Political and economic forces stand out as being the most powerful; the power obviously rests with the government. Positive and negative pressure has tended to be closely linked with the economic determinant, thus the Department of Health has enjoyed considerable freedom in ordering diploma nursing education in a direction of choice. In the Atlantic provinces, the force most frequently quoted as militating against change is the economic factor. Groups contend that provinces stand to lose financially if a move to the educational systems is effected, but other provinces have found solutions to the same problem; time may be needed to more clearly determine real and unreal forces which militate for or against change.

The trend away from a hospital-oriented type of learning and toward a college-centered pattern of education has therefore permeated the Canadian scene; forces propelling this trend, almost identical in all provinces, are fourfold. Diploma nursing education, in a manner similar to other types of education, increasingly falls within the jurisdiction of provincial governments, hence the trends in and characteristics of programs across Canada discussed below consist of a blending of trends thus designing a pattern which is unique to our country.

2. Structural Organization and General Policies Governing Diploma Nursing Programs.

In Canada, the trend is away from the control of the provincial Departments of Health and toward the control and scrutiny of the Departments of Education; away from the three year pattern and toward a shorter program. With the exception of the province of Quebec, the length of diploma nursing programs is generally of a two year duration although the term two years is variously used. Table XIX presents a comparative analysis of the length of programs in years and in months. In five provinces, the entire program is compressed within a two year period. Quebec is the only province with a program of three academic years. The length of the program, however, consists of twenty-four months, this being only two months more than that of four other provinces. The one existing college program in Manitoba has the shortest program, namely twenty months. Table XIX further demonstrates that the total years of formal schooling considered a prerequisite to gain

TABLE XIX

Entrance Requirements, Minimum Length of Formal Schooling and Nursing Education Required by Province to Complete a Course in Diploma Nursing Established in Educational Institutions[a].

Provinces	Entrance Requirements	Length of Education		
		Formal Schooling Years	Diploma Program	Total Years
B.C.	Grade XII	12	2	14
Alta.	Grade XII	12	2	14
Sask.	Grade XII	12	2	14
Man.	Grade XII	12	2	14
Ont.	Grade XII	12	2	14
Que.	Secondary V	11	3	14

[a] SOURCE: Information compiled from data presented in Chapters II-VIII under "structural organization" and "Curriculum" of this study.

entrance in diploma programs in five of the six provinces is twelve years. Here again exception is made for the province of Quebec which requires only eleven years of formal schooling. Regardless of the minor difference in the duration of diploma nursing programs, candidates across Canada require fourteen years of schooling to obtain a diploma in nursing. Although there are no diploma nursing programs within the system of education in the Atlantic provinces, Chapter VIII reveals that with the exception of Newfoundland which requires eleven years, a total of twelve years of formal schooling is compulsory to gain admission in schools of nursing.

Diploma nursing programs within the systems of education in Canada are, without exception, established in multidisciplined institutions at the post-secondary level. These institutions are of two types: technical institutes and junior or community colleges. Table XX presents, by

province, the precise nature and nomenclature of the educational institutions within which diploma nursing programs are being developed. As programs move away from hospitals and toward colleges, they automatically come under the Departments of Education and are therefore no longer under the control of the Departments of Health. Table XX further presents a summary of the various Departments of Education responsible for the control and scrutiny of educational institutions within provinces.

All diploma nursing programs within the educational systems are controlled, financed and administered by the educational institution in the way that other similar programs are controlled, financed and administered. The institutions are responsible for the funding of programs, but nursing students pay tuition fees which are comparable to that of other college students. The tuition fee structure varies between and even within various provinces. Quebec presents a unique feature in that full time students in CEGEP are not required to pay tuition fees. British Columbia is likewise unique in that nursing students receive a monthly stipend of $150.00 from the Department of Health. In this province, it is further observed that the yearly tuition fee ranges from $180.00 in one institution to $375.00 in another. In Canada, the lowest and highest yearly tuition fees identified were that of $175.00 in Alberta, and the previously indicated fee of $375.00 in British Columbia.

Table XXI* embodies information with regard to the nature and year of last revision of standards directing diploma nursing programs, as well as the authority designated to set same. The trend is for Departments of Education to become increasingly active in establishing standards and educational requirements. In the provinces of Ontario and Quebec the Ministries of Education now assume responsibility for the prescription of norms relative to the total program. The ONQ, however, by virtue of the *Professional Code*, and the *Nurses Act*, enjoys the prerogative of cooperating in the elaboration of the prescribed curriculum. Despite the fact that the Council of Regents, Ministry of Colleges and Universities of Ontario, in 1973, became the responsible body for the setting and maintenance of standards, the College of Nurses, which previously assumed this responsibility, continues its evaluation role with diploma nursing programs in the colleges of applied arts and technology for an interim three year period. In Alberta, according to provisions made in the Nurses Act, responsibility for the prescription, control and maintenance of standards has always been vested in the Universities Co-ordinating Council, but this role is progressively questioned. Changes are imminent, but it remains unclear as to what body will be vested with this authority.

The authority to prescribe, control, maintain standards, and the authority to grant approval to diploma nursing programs in respective provinces tends to be vested in the same body. Table XXII** indicates the recognized authority, for each of the ten provinces, to grant approval to diploma nursing programs. In the Atlantic provinces, this reponsibility is assumed by respective provincial nurses associations. The programs therefore tend to be approved by the nursing body which is simultaneously the legally established body to grant registration certificates to its members. The Department of Continuing Education of Saskatchewan approves all programs established within Institutes of Applied Arts and Sciences, but the SRNA sets standards and approves diploma nursing programs for purposes of registration. With the eventual proclamation of the *Health Disciplines Act* in Ontario, the Nurses Act will be rescinded, hence the role of the College of Nurses, considerably altered, will consist in developing regulations

* Reproduced in Figure 5, p. 102.
** Reproduced in Figure 6, p. 103.

Table XX

Type and Control of Educational Institutions within which Diploma Nursing Programs are Established in Respective Provinces[a].

Province	Type of Institution	Control
B.C.	Community Colleges	Boards of School Trustees Department of Education
	Technical Institute (BCIT)	Department of Education but under the Director of Technical and Vocational Training
Alta.	Junior Colleges	Department of Advanced Education
Sask.	Institutes of Applied Arts and Sciences	Department of Continuing Education
Man.	Community College	Department of Colleges and University Affairs
Ont.	Colleges of Applied Arts and Technology (CAAT)	Council of Regents, Ministry of Colleges and Universities
Que.	General and Vocational Colleges (CEGEP)	Direction Generale de l'Enseignement Collegial, Ministry of Education

[a]SOURCE: Information compiled from data presented in Chapters II–VIII under "Structural Organization" of this study.

outlining requirements for registration rather than requirements for approval of programs. Changes may likewise be anticipated in British Columbia where, by virtue of the *Medical Centre of British Columbia Act,* the Medical Centre now makes recommendations to the government concerning the initiation of diploma nursing programs. The responsibility of approval of schools of nursing for registration purposes, however, still rests with the RNABC. In Manitoba, an Accreditation Committee consisting of wide representation, established under provisions of the Nurses Act, assumes full responsibility for the setting of standards and the granting of approval to diploma nursing programs.

With the transfer of diploma nursing programs to the system of education, the trend in Canada is toward a more centralized form of control of programs by the Department of Education. Conversely, the trend is less for nursing associations to gain than to lose control over diploma nursing programs; they tend to continue as regulatory bodies while enjoying lesser or no privileges over educational programs.

The trend in Canada is therefore away from a multi-jurisdictional form of approval of diploma nursing programs, and toward a more central form of control by the Departments of Education. Provincial nurses associations, which in the past played a very vital and important role in diploma nursing education, are rapidly becoming mere regulatory bodies. Their role, by means of the granting of registration certificates, is increasingly that of protecting the public against incompetent members; registration being an accepted system whereby the qualified and unqualified are distinguished.

Registration, certification or licensure, all three tending to be variously used, are a provincial responsibility. Presently, there are ten legally constituted bodies, nine provincial associations and one college of nurses, for registration and certification of members.

SOURCE: Letourneau, M. "Trends in Basic Diploma Nursing Programs within the Provincial Systems of Education in Canada 1964 to 1974." Unpublished Doctoral Dissertation. The University of Ottawa, Ottawa, 1975: 332-348.

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